



TOWARDS THE CAMISATION OF HEALTH?

**THE COUNTERVAILING POWER OF CAM IN RELATION TO
THE PORTUGUESE MAINSTREAM HEALTHCARE SYSTEM**

THESIS

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BY

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DECLARATION OF AUTHORSHIP

I Joana Almeida hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: Joana Almeida

Date: November 2012

ABSTRACT

The aim of the research reported here is to answer the following primary research questions: Is the relationship between CAM, the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred? Two CAM therapies, acupuncture and homeopathy, have been chosen as case studies. The main sources of data were in-depth individual interviews and documents. The research sample (n=41) was made of three groups of interviewees: (1) 20 traditional CAM practitioners, (2) 10 orthodox medical doctors not committed to CAM and (3) 11 orthodox medical doctors committed to CAM.

This research draws on a neo-Weberian perspective of professions which emphasises the power relations between related occupational groups who seek to gain or maintain power and status in their field of work. This research also makes extensive use of the concept of ‘countervailing powers’ (Light, 2010), as it attempts to illuminate the influence of CAM practitioners on Portuguese healthcare, as well as the influence of other powerful players, such as the State, and major corporations, such as pharmaceutical and health insurance companies, on CAM’s relationship with the medical profession.

On the basis of this research, I argue that the relationship between CAM, the medical profession and the State has changed in Portugal over the last 16 years. I suggest a concept that helps to explain CAM practitioners’ recent countervailing actions within the Portuguese mainstream healthcare. This concept is ‘camisation’, a process through which everyday human problems are transformed into health problems which are treated in CAM terms and within a CAM framework. Although the main drivers of camisation have been CAM practitioners, I also show how the Portuguese State, the medical profession and the pharmaceutical industry have all been active collaborators in this process, whilst maintaining different interests and constantly bargaining and negotiating to maximise their power and status within the field of healthcare.

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LIST OF ABBREVIATIONS

Abbreviations that are used in this thesis are listed below in alphabetical order.

APAMTC	Associação Profissional de Acupuntura e Medicina Tradicional Chinesa (Professional Association of Acupuncture and Traditional Chinese Medicine)
APA-DA	Associação Portuguesa de Acupuntura e Disciplinas Associadas (Portuguese Association of Acupuncture and Related Disciplines)
APH	Associação Portuguesa de Homeopatia (Portuguese Association of Homeopathy)
APMA	Associação Portuguesa de Medicina Acupunctural (Portuguese Association of Acupunctural Medicine)
APS	Associação Portuguesa de Sociologia (Portuguese Sociological Association)
ARP	Assembleia da República Portuguesa (Portuguese Assembly of the Republic)
BSA	British Sociological Association
BE	Bloco de Esquerda (left wing Bloc)
CADA	Comissão de Acesso aos Documentos Administrativos (The Commission on Access to Administrative Documents)
CAM	Complementary and alternative medicine (‘CAM’s’ is sometimes used as shorthand for ‘complementary and alternative medicine therapies’)
CAQDAS	Computer Assisted Qualitative Data analysis
CCRN	Comissão Coordenadora para a Regulamentação da Naturologia (Committee for the Coordination of the Regulation of Naturology)
CDS-PP	Centro Democrático Social (Democratic and Social Centre – People’s Party)
CDU	Coligação Democrática Unitária (Democratic Unity Coalition)
CESC	Committee on Education, Science and Culture (Comissão de Educação, Ciência e Cultura)
CHD	Committee on Health and Drugs (Comissão de Saúde e Toxicodependência)
CNNET	Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas

	não Convencionais (an aspiring CAM Council)
CTCTNC	Comissão Técnica Consultiva das Terapêuticas não Convencionais (Consultative Technical Committee on CAM)
DGS	Direcção-Geral da Saúde (General Directorate of Health)
EAN	Estudos Avançados de Naturologia (Advanced Studies in Naturology)
EFCAM	European Forum for Complementary and Alternative Medicine
ESMTC	Escola Superior de Medicina Tradicional Chinesa (Graduate School of Traditional Chinese Medicine)
ESTAL	Escola Superior de Tecnologias e Artes de Lisboa (Lisbon Graduate School of Technology and Arts)
EU	European Union
FENAMAN	Federação Nacional de Associações de Medicinas Alternativas Naturais (National Federation of CAM Associations)
ICBAS/UP	Instituto de Ciências Biomédicas Abel Salazar, Universidade do Porto (Abel Salazar Biomedical Science Institute, University of Porto)
INE	Instituto Nacional de Estatística (Statistics Portugal Institute)
INFARMED	Autoridade Nacional do Medicamento e dos Produtos de Saúde I.P. (National Authority on Pharmacy and Medicinal Products)
IMTC	Instituto de Medicina Tradicional Chinesa (Traditional Chinese Medicine Institute)
IPN	Instituto Português de Naturologia (Portuguese Institute of Naturology)
LADA	Lei do Acesso aos Documentos Administrativos (Act for the Access to Administrative Documents)
MA	Medical Acupuncturist
MCIES	Ministério da Ciência, Inovação e Ensino Superior (Ministry of Science, Innovation and Higher Education)
ME	Ministério da Educação (Ministry of Education)
MH	Medical Homeopath
MPT	Movimento Partido da Terra (Earth Party Movement)
MS	Ministério da Saúde (Ministry of Health)
NCCAM	American National Center for Complementary and Alternative Medicine
NHS	National Health Service

PCP	Partido Comunista Português (left wing Communist Party)
PEV	Partido Ecologista ‘Os Verdes’ (Ecologist Party ‘The Greens’)
PMC	Portuguese Medical Council (Ordem dos Médicos Portuguesa)
PPD-PSD	Partido Popular Democrático (right-of-centre Social-Democratic Party)
PS	Partido Socialista (left-of-centre Socialist Party)
SALVA	Associação Internacional de Medicinas Tradicionais e Actividades Saudáveis (International Association of Traditional Medicine and Healthy Activities)
SHP	Sociedade Homeopática de Portugal (Homeopathic Society of Portugal)
SPH	Sociedade Portuguesa de Homeopatia (Portuguese Society of Homeopathy)
S.P.M.A.	Sociedade Portuguesa Médica de Acupunctura (Portuguese Medical Society of Acupuncture)
SRNOM	Secção Regional Norte da Ordem dos Médicos (Portuguese Medical Council – North Department)
TA	Traditional Acupuncturist
TCM	Traditional Chinese Medicine
TH	Traditional Homeopath
TSF	Telegrafia sem Fios (wireless Telegraph)
UMC	Universidade Medicina Chinesa (Chinese Medicine University)
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

The issue of the relationship between well-established occupations and lower status, subordinate occupations has been comprehensively researched in the sociology of professions. Within the healthcare arena, the conflict between medicine – seen as the prototype of a dominant healthcare profession (Freidson, 1970a; MacDonald, 1995) – and other subordinate professions such as nursing, midwifery and physiotherapy, is also a longstanding issue in the sociology of professions. In the last decades, however, as a response to the ‘revival’ of complementary and alternative medicine (CAM) (Cant and Sharma, 1999) and the subsequent claims made by CAM practitioners for legitimacy, sociological research on the changing relationship between CAM and the medical profession has increased in countries other than Portugal. This existing research has also brought to the fore the role of key players such as the State, the lay populace and health corporations in influencing this relationship.

The research reported in this thesis therefore explores the hitherto neglected relationship between CAM, the medical profession and the State in Portuguese society over the last 16 years. It is also concerned with the influence of corporate powers such as the pharmaceutical industry on that relationship. The current interplay between CAM and these specific groups will be examined through case studies on acupuncture and homeopathy. The original concept of ‘camisation’ is introduced in this analysis to refer to CAM practitioners’ attempts to encroach upon mainstream healthcare in Portugal. However a note of caution about the wider applicability of this new concept is in order here as it describes a process that may be specific to context, time and particular CAM therapies, i.e., to acupuncture and homeopathy within the Portuguese society at the dawn of the 21st century.

This introduction presents the main aims of the thesis and a short description of the theoretical framework adopted. The rationale for the choice of acupuncture and homeopathy as two cases in point is then presented, before some main definitional considerations are addressed. Finally, the structure of the thesis will be outlined.

1.1. Aims of the Thesis

There are two main reasons why sociologists should consider analysing the relationship between CAM, the medical profession and the State within the Portuguese context. On the one hand, recent changes in Portuguese legislation with respect to CAM have put Portugal amongst those countries with governmental support for the increasing convergence of CAM and orthodox medicine. The UK, the Netherlands, Germany, Canada, the USA and Australia are other good examples of this trend. In July 2003, Portuguese parliament passed a new Act 45/2003 (*Lei do Enquadramento Base das Terapêuticas não Convencionais*) concerning the recognition and regulation of six CAM therapies: acupuncture, homeopathy, osteopathy, naturopathy, fitotherapy and chiropractic. This new Act defined CAM therapies as ‘non-conventional therapeutics’ and this new term became commonly used by the CAM community in the country. The Act came into force on the 22nd of August 2003 (ARP, 2003a), yet it has to be implemented. So it seems that Portugal has undergone, although tardily, a similar process to other countries, which makes the country an interesting case for analysis.

On the other hand, this new Act raises crucial sociological questions about the current status of the medical profession and CAM practitioners within Portuguese mainstream healthcare, the current relationship between CAM and the Portuguese medical profession, and the power of key actors such as the State and corporations such as the pharmaceutical industry to interfere in that relationship and in enhance CAM legitimacy in the country. To date there has been little sociological interest and research conducted on this matter in Portugal. So, a second reason for undertaking this research is that it seems an opportune time to gain some insight into such a neglected issue in Portuguese sociological research.

The overarching research questions that guided this study are the following: Is the relationship between CAM, the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred? Along with this question, this study has generated seven more subsidiary research questions:

- What main strategies have CAM practitioners used to promote alternative conceptualisations of healing within mainstream healthcare in Portugal?

- To what extent has the Portuguese political context sustained the success of CAM practitioners' strategies?
- To what extent have CAM practitioners and the medical profession influenced State policy in Portugal?
- To what extent has CAM been incorporated into the medical establishment in Portugal?
- How have orthodox medical doctors responded collectively to CAM practitioners' attempts to influence healthcare provision in Portugal?
- How have medical acupuncturists and medical homeopaths responded to CAM practitioners' attempts to encroach upon healthcare provision in Portugal?
- To what extent has the interplay between the medical profession and CAM practitioners in Portugal been consensual?

These subsidiary research questions are best answered through qualitative research methods. As acknowledged by Light and Hughes (2002), the power of [qualitative] sociological analysis draws upon the act of revealing the power relations and deep structures that underlie the rhetoric and practices of individuals, groups and organisations. Since the answer to the research questions presented have to be found in the rhetorical discourses and practices of individuals and organisations, an interpretative and qualitative approach to the topic studied has been adopted. Individual semi-structured interviews and documents have been used as main methods of data collection.

1.2. Theoretical Framework

The research presented here cuts across medical sociology, sociology of professions and sociology of CAM. It draws on a neo-Weberian approach to professions which looks at the latter as being in frequent conflict and competition with related professions for higher status and power (Saks, 1995a). Traditionally related to this approach have been the concepts of (vested) 'interests' and 'strategies' used by professional groups and/or individual professionals to achieve an outcome of a certain kind. Whilst recognising that the sociological debate around such concepts is long and nebulous (see, for instance, Saks's discussion about the lack of a clear definition of 'interests', 1995a), in the

research reported here the concept of 'interests' is defined purely in terms of expectations, wants, preferences or desires of a professional group and/or individual professionals to achieve status and power in the health field. In other words it is defined in subjective terms. The concept of strategy, can be seen as closely related to the notion of interests as it is taken as referring to the tactics, actions or mechanisms put in place by professional groups and/or individual professionals to bring about their own desires or wants, in this case in the health domain.

Furthermore, this research makes extensive use of the concept of 'countervailing powers' (Light, 2010; 2005, 2000; 1995) in order to show the complexity of the healthcare field, where not only CAM and the medical profession but also other powerful actors such as the State and health corporations have had a stake. Finally, this research also draws on Abbott's (1988) systemic view of professions and in particular his concept of 'jurisdictional vacancies'. The idea behind this concept is that professions face some well-recognised problematic conditions for which diagnosis and treatment are currently far from effective, leading to a threat of patient-poaching by related professions.

The framework presented here thus offers a dynamic perspective of healthcare, which takes into consideration the interaction of various interest groups in reshaping healthcare markets and in repositioning power relations within those markets over time. This perspective is in line with a neo-Weberian approach to the professions in that it accounts for boundary changes between professional groups through the use of professional power and political and social pressure (Saks, 1983). This perspective should also be situated within the wider social condition of postmodernity or, as Bauman (2000) proposes, 'liquid modernity'. Advocates of the latter have stated that current societies are 'boundary-breaking', in the same way as liquid, which does '... not keep to any shape for long and [is] constantly ready (and prone) to change' (Bauman, 2000:2). Healthcare has been a great example of a field where postmodern thought has become prominent and has shaped action, through hybridisation and fragmentation of epistemologies, practices, treatments and methods, at the level of the individual healthcare professional, and also at the institutional level of the State or health corporations, whose interests have increasingly aligned to those of CAM practitioners. As Saks (1998) pointed out, CAM could be seen as symptomatic of a move towards a postmodern thought, as it has given rise to a diversity of discourses in the healthcare

arena and has contributed to the fragmentation of health knowledge in contemporary Western society.

As stated before, the research presented here concentrates on the analysis of two specific CAM therapies, acupuncture and homeopathy. The reasons for having chosen these two CAM therapies will be now presented.

1.3. Why Acupuncture and Homeopathy?

A first and immediate reason for the choice of acupuncture and homeopathy is that both are included in the list of six CAM therapies under statutory regulation in the country, according to the Portuguese Act 45/2003. Out of these six CAM's, acupuncture and homeopathy best exemplify two therapies which can be contrasted in terms of: (1) their nature; (2) their level of medical legitimacy and (3) their degree of 'incorporation' (Saks, 1995a), 'co-option' (Baer, 2001; Baer and Coulter, 2008) or 'accommodation' (Callahan, 2002) to a biomedical model of health.

Acupuncture is a non-medication technique found in Traditional Chinese Medicine, or a procedure-based therapy (WHO, 2002) which consists in needling specific parts of the body in order to heal and has acquired status as a complementary form of medicine in mainstream healthcare. As Chapter Two will show, acupuncture is a CAM therapy with a higher degree of 'incorporation' (Saks, 1995a), 'co-option' (Baer, 2004) and 'accommodation' (Callahan, 2002) with the biomedical model, by having moved from a marginal to a limited medical practice worldwide (Gort and Coburn, 1988; Wardwell, 1994; Saks, 1995a, 2000a, 2003; Cant and Sharma, 1996a; Cant, 1996; Baer et al., 1998b; Gilmour et al., 2002; Hirschhorn and Bourgeault, 2005). The aforementioned studies have shown that acupuncture has changed the context and the content of its work; it has developed an organisational structure and has altered its knowledge base in accordance with a biomedical model.

Homeopathy, in turn, presents as a whole medical system which involves herbal and chemical medication and proposes to be alternative to many biomedical procedures. Despite engaging in knowledge based transformations and organisational progress, and despite having increased its legitimacy worldwide, homeopathy has witnessed from time to time a resurgence of protest from the medical orthodoxy, which has pressurised national governments and supranational organisations to ban this therapy from

mainstream healthcare. Since homeopathic knowledge draws on principles that are opposite to those of the medical orthodoxy, this therapy remains controversial and has consequently become more marginalised than acupuncture in Portuguese society.

The interest in studying, on the one hand, a non-medication therapy with an increasing complementary status in relation to medical orthodoxy and, on the other hand, a medication therapy which has not evolved into a complementary status in the same way as acupuncture and remains mostly alternative to the biomedical model, was the rationale for the choice of acupuncture and homeopathy as the two case studies. We turn next to definitional issues and elucidate how certain key terms are employed in this research.

1.4. Terminology

This research draws on terms such as ‘complementary and alternative medicine’, ‘acupuncture’ and ‘homeopathy’. These are terms that, along with ‘orthodox medicine’, ‘medical acupuncture’, ‘medical homeopathy’, ‘medical acupuncturist’, ‘medical homeopath’, ‘traditional acupuncturist’ and ‘traditional homeopath’ need to be defined in more detail as they will be frequently used in the findings section.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) has been presented as a controversial concept in sociological research. Firstly, the terms ‘complementary’ and ‘alternative’ run parallel to each other despite suggesting different relationship with biomedicine. The term ‘complementary medicine’ refers to the use of CAM alongside conventional medicine, such as using acupuncture in addition to other orthodox medical procedures like conventionally prescribed medicines to help reduce or manage pain. With this in mind, some researchers (Willis, 1994) suggest that the term ‘complementary medicine’ implies a convergence between CAM and orthodox healthcare. The term ‘alternative medicine’, on the other hand, implies a divergence and refers to the use of CAM in place of conventional medicine (NCCAM, 2010), to be used as a first resort or after an array of conventional treatments have been attempted.

Secondly, CAM is controversial because it is a broad and ambiguous concept whose boundaries are constantly changing (NCCAM, 2010). The American National Centre

for Complementary and Alternative Medicine (NCCAM; 2010:1), for instance, points out that the ‘... boundaries between CAM and conventional medicine are not absolute, and specific CAM practices may, over time, become widely accepted’. Furthermore, a booming alternative healthcare market since the late 1960s has led to an arbitrary incorporation of alternative approaches, procedures and methodologies within CAM which sometimes have little in common. In the UK, for instance, researchers (Cant and Sharma, 1999:52) estimate that currently more than one hundred and sixty CAM therapies are used by patients and that they differ in the way they are organised and in the way they treat patients. They span a range of medical systems, which include traditional Chinese medicine, ayurvedic medicine, unani medicine, homeopathy or naturopathy. There are also well-known therapies such as massage, reflexology, manipulation, self-care and self-knowledge techniques such as meditation, mind-body interventions, diet or nutritional therapy. Finally, there are also more hermetic models of healing, such as spiritual healing, positive thought or mental healing and crystal healing (Cant and Sharma, 1999).

In the opinion of scholars such as Wolpe (2002), CAM constitutes what sociologists have called a ‘residual category’, created not because of the existence of consistent criteria or internal coherence, but as a consequence of being excluded by other categories of medicine. They are, therefore, practices which do not satisfy the values of the Western biomedical perspective and are relegated to residual categories of little interest to science (Wolpe, 2002:165-166).

For Goldstein (1999), however, it seems clear that CAM therapies, although terminologically ambiguous and arbitrary, have a cohesive set of characteristics in common that makes them not a mere residual list of techniques, but a coherent conceptual category with the capacity to interpret the world and to act on it with a certain logic. As he (1999:10) put it, ‘it would be a mistake to think of alternative medicine as merely a name for a residual list of techniques omitted from the standard medical school curriculum’.

The recent trend towards the ‘incorporation’ (Saks, 1995a) of CAM by the medical profession, however, has suggested other interesting definitions such as the following provided by Wolpe (2002:165):

The emergence of CAM thus is a marketing phenomenon, but in the most noble sense of that word – it is a way [for the medical profession] to respond to society's demand to reinvigorate the 'art' of medicine, its attention to the subjective, ritualized, and mythological, under the guise of scientific scrutiny.

According to Wolpe (2002), the emergence of CAM has been a device used by the medical profession to recover old models of medical practice that have been lost over time. So, as one can see, there is no consensus regarding the definition of CAM. It is not the purpose here, however, to debate whether the concept of CAM is an appropriate term to use in sociology. This term will be used here for convenience, due to its mainstream use in contemporary sociological research and by supra-State organisations such as the World Health Organisation (WHO). It will also adopt the WHO's (WHO, 2000:1) definition of CAM which is as follows:

The term complementary and alternative medicine is used in some countries to refer to a broad set of healthcare practices that are not part of the country's own tradition and are not integrated into the dominant healthcare system.

Traditional Acupuncture

Traditional acupuncture, also called in this study 'classical acupuncture' or just acupuncture, is an ancient therapeutic technique of Chinese medicine which involves inserting small needles in different points in the body (Gwei-Djen and Needham, 1980). It is thus a 'non-medication' therapy (WHO, 2002). In its classical form, it is a main component of Traditional Chinese Medicine and '... is based on the idea of 'qi' (vital energy) which is said to travel around the body along 'meridians' which the acupuncture points affect' (House of Lords, 2000). A more detailed definition of traditional acupuncture is also given by the WHO (2001:2):

[Acupuncture's] diagnosis and treatment are based on a holistic view of the patient and the patient's symptoms, expressed in terms of the balance of *yin* and *yang*. *Yin* represents the earth, cold, and femininity. *Yang* represents the sky, heat, and masculinity. The actions of *yin* and *yang* influence the interactions of the five elements composing the universe: metal, wood, water, fire, and earth. Practitioners of traditional Chinese medicine seek to control the levels of *yin* and *yang* through 12 meridians, which bring energy to the body.

According to the WHO (2001), acupuncture is the most widely used CAM therapy and is practised in every region of the world. However, as Saks (1995a) stated, despite the higher credibility given to acupuncture by the medical profession in most Western

countries in the contemporary era, this therapy has not yet abandoned its status as a CAM therapy. In the study reported here, traditional acupuncture is largely practised by ‘traditional acupuncturists’.

Traditional Homeopathy

Traditional homeopathy, also called in this study ‘classical homeopathy’ or just homeopathy, presents as a nineteenth-century nonallopathic medicinal system (Fulder, 1996) developed by Samuel Hahnemann, a German physician. It is based on three main principles: (1) ‘the simile’, or the idea that treatment should be based on a drug-symptom similarity (Nicholls, 1988), i.e. the idea that the disease is eliminated through drugs which would produce the same symptoms as the ones from the disease if administered to a healthy person; (2) the principle of the minimum dose, which contrasts to the biomedical perspective where doses can be increased by combining different drugs (Nicholls, 1988); and (3) the principle of high dilution or potency, i.e. the idea that remedies can retain their power after being ‘potentised’ (diluted and agitated beyond the Avogadro’s¹ number), from which it is scientifically believed that no more molecules of the original substance remain (Degele, 2005). In short, homeopathy presents itself as a Western medicinal system with an ideology of healing which is largely in contrast to biomedicine², yet which also lays claim to the use of medicinal substances with a pharmacological or chemical influence (Nicholls, 1988). Nevertheless, the homeopathic pharmacopeia is considered very distinctive and antagonistic to the biomedical one, due to the principles outlined above. In the research reported here, ‘traditional homeopathy’ is generally practised by ‘traditional homeopaths’.

Orthodox Medicine

Orthodox medicine refers to the institutionalised medicine grounded in a scientific logic and an evidence-based ethos and with political legitimacy (Saks, 2003). Other terms, such as ‘conventional’, ‘allopathic’, ‘Western’, ‘modern’, ‘contemporary’, ‘regular’, ‘normative’, ‘evidence-based’ medicine, and ‘biomedicine’ will be used interchangeably. ‘Orthodox medicine’ is generally practised by holders of a medical degree such as medical doctors in Western countries.

¹ The calculated number of atoms or molecules in a substance.

² Although biomedicine often uses treatments based on the simile principle such as vaccination (Nicholls, 1988).

Medical Acupuncture

Medical acupuncture, sometimes also called ‘Western acupuncture’, refers in this study to acupuncture practised by orthodox medical doctors and allied healthcare professionals in Western countries. Medical acupuncture is usually limited to a ‘narrow sphere of operation’ (Saks, 1995a) such as the relief or management of pain. According to White and the Editorial Board of *Acupuncture in Medicine* (2009, p.33), a Journal published by the *British Medical Journal’s* group, medical acupuncture is defined in the following way:

Western medical acupuncture is a therapeutic modality involving the insertion of fine needles; it is *an adaptation of Chinese acupuncture using current knowledge of anatomy, physiology and pathology, and the principles of evidence based medicine*. While Western medical acupuncture has evolved from Chinese acupuncture, *its practitioners no longer adhere to concepts such as Yin/Yang and circulation of qi, and regard acupuncture as part of conventional medicine* rather than a complete ‘alternative medical system’. *It acts mainly by stimulating the nervous system ... Western medical acupuncture is principally used by conventional healthcare practitioners, most commonly in primary care. It is mainly used to treat musculoskeletal pain ... It is also effective for postoperative pain and nausea* (my emphasis).

This statement defines ‘medical acupuncture’ as a biomedicalised practice; as an adaptation or co-option (Baer, 2001) of traditional Chinese acupuncture by a biomedical discourse and knowledge. ‘Medical acupuncture’ thus evolves from ‘traditional acupuncture’ but no longer takes into account the classical ideological background of this therapy. Moreover, medical doctors in Portugal are the only professionals with formal qualifications to practice ‘medical acupuncture’, although in other Western developed countries this new medical competency is also practised by other conventional healthcare practitioners such as nurses, physiotherapists, midwives, nutritionists, etc. In the study reported here, ‘medical acupuncture’ is practised by ‘medical acupuncturists’.

Medical Homeopathy

Contrary to acupuncture, there is no definition of ‘medical homeopathy’ as an evolved form of ‘traditional homeopathy’. That is to say, the classical definition of homeopathy remains hegemonic and homeopathy has not been biomedicalised. This also means that homeopathy as usually defined is legitimised by both ‘traditional homeopaths’ and ‘medical homeopaths’. Medical homeopathy is thus defined in this study merely in

terms of its growing interest and use among biomedical professionals. Nevertheless, one could argue that some biomedicalised forms of homeopathy have developed such as ‘symptomatic homeopathy’ which, as Chapter Nine will show, is a form of homeopathy perceived by some participants as detached from its holistic philosophy and which tends to follow clinical guidelines. In the study reported here, ‘medical homeopathy’ is practiced by ‘medical homeopaths’.

Traditional Acupuncturists

Also called ‘non-medically qualified acupuncturists’, ‘traditional acupuncturists’ represent in this study unregulated healthcare professionals usually with training in traditional Chinese medicine of which ‘traditional acupuncture’ is a part. Traditional acupuncturists acquire training outside the realms of biomedicine and outside or inside the country. They have no access to ‘medical acupuncture’ courses regulated by the Portuguese Medical Council, as they generally do not hold a medical degree. They remain unregulated by the Portuguese State.

Traditional Homeopaths

Also called ‘non-medically qualified homeopaths’, ‘traditional homeopaths’ represent in this study unregulated healthcare professionals who have acquired training in ‘traditional homeopathy’ outside the realms of biomedicine and outside or inside Portugal. They generally share a classical view of homeopathy, yet with some internal divisions about the meanings of this therapy. Traditional homeopaths do not usually hold a medical degree and remain unregulated by the Portuguese State.

Medical Acupuncturists

‘Medical acupuncturists’ refer in this study to conventional medical doctors who have acquired accreditation in medical acupuncture by the Portuguese Medical Council (PMC) or, having not acquired this accreditation, still use this therapy in their medical practice. They are differentiated as accredited or non-accredited medical acupuncturists.

Medical Homeopaths

‘Medical homeopaths’ refer in this study to conventional medical doctors who have acquired training in homeopathy inside or outside Portugal and who have incorporated

it into their medical practice. They are not accredited medical homeopaths, as there is no accreditation in medical homeopathy in Portugal. They make part of a 'deviant population' (Lee, 1999), as medical doctors in Portugal are not allowed to practise homeopathy.

We now turn to the next section and look at the structure of the thesis to be presented here.

1.5. Structure of the Thesis

This thesis is organised into 10 Chapters. In Chapter Two, an extensive review of the literature on CAM's changing relationship with the medical profession and the State in Western society is presented. The chapter charts the dynamics of this relationship from ancient Greece to the twenty-first century. This review resulted in a number of research questions, which are outlined at the end of the chapter. In Chapter Three, the methodological approach of the study is described. The research sample was made up of the following groups: 10 traditional acupuncturists, 10 traditional homeopaths, 10 orthodox medical doctors not committed to CAM (5 general practitioners and 5 surgeons) and 11 orthodox medical doctors committed to acupuncture and/or homeopathy.

The set of six empirical chapters starts with Chapter Four, where the strategies used by CAM practitioners to integrate themselves into Portuguese mainstream healthcare are analysed. The nature of the countervailing actions of CAM practitioners in order to camicise healthcare is presented. The new concept of 'camisation', defined in this introduction as the process by which everyday human problems are transformed into health problems which are treated in CAM terms and within a CAM framework, is also introduced in Chapter Four. The focus of Chapter Five is on the policy-making process around CAM, involving the countervailing powers of CAM practitioners, the State, the political parties and the medical profession since 1996, a turning point date in the political interest in CAM in the country. In Chapter Six the institutional position of the Portuguese Medical Council (PMC) towards CAM is analysed by comparing acupuncture and homeopathy. It will reveal how this dominant body of the medical profession has responded to these CAM therapies in a differential way.

In the next two chapters, Chapters Seven and Eight, the responses of medical doctors to CAM therapies and CAM practitioners in Portugal are examined. Chapter Seven concentrates on the collective responses of orthodox medical doctors (uncommitted to CAM) towards the recent countervailing actions of CAM practitioners to achieve legitimacy; Chapter Eight focuses on the responses of orthodox medical doctors committed to CAM, i.e. ‘medical acupuncturists’ and ‘medical homeopaths’, to the attempts of CAM practitioners to encroach upon Portuguese mainstream healthcare. In Chapter Nine, an intra-occupational perspective is adopted and the internal fragmentation within the medical profession and CAM concerning CAM in Portugal is analysed.

Finally, in Chapter Ten the research questions, their answers and the key findings are outlined in the form of main themes. Finally, suggestions are made for future research.

CHAPTER TWO

CAM'S CHANGING RELATIONSHIP WITH THE MEDICAL PROFESSION AND THE STATE IN WESTERN SOCIETY: A REVIEW OF THE LITERATURE

2.1. Introduction

This chapter offers a critical and selective review of the literature on the changing relationship between CAM, the medical profession and the State in Western society. It is segregated into four different fields: the history of medicine; the sociology of professions; medical sociology; and political sociology. The intersection of these fields sheds light on various conceptualisations which provide a useful framework for the subsequent analysis of the recent encroachment of CAM treatments and solutions upon Portuguese society.

This chapter is divided into five main sections, each focusing on particular themes and concepts: (1) the historical context of the relationship between orthodox and heterodox medical practice; (2) CAM and postmodernity; (3) CAM's professional project; (4) the changing relationship between CAM and the medical profession; (5) the field of countervailing powers. The first section primarily contains historical material on the interplay between orthodox and heterodox medical practice within the context of Western medicine. The second section presents the view of CAM as an interest group in a postmodern context. Both sections critically examine views which subsequently help contextualise the following sections. In light of this, they do not lead to a specific research question. The analysis of sections 3 and 4, however, generated a number of subsidiary questions which are summarised in the conclusion of this chapter. Finally, Section 5 uses a countervailing power theory to show the interdependent character of the actions of CAM practitioners, the medical profession, the State, the supra-State organisations and health corporations such as the pharmaceutical industry or health insurance companies in the healthcare field.

2.2. The Historical Context of the Relationship between Orthodox and Heterodox Medical Practice

This section will provide a historical overview of the boundary-drawing conflict between orthodox and heterodox medical practice from the ancient Greece to the mid-

20th century. It will be suggested that ‘normative healing’ has been culturally and socially redefined over time and is a variable ‘... of time, place, and the attitudes of healthcare practitioners’ (Frohock, 2002:214). Furthermore, it will be argued that heterodox medical practices have from time to time resurged and challenged the existing order within healthcare. Whilst recognising the limitations of the summary character of this historical context, which is far more complex than presented here, the exploration of ideas in this section is important as it lays the foundations for the following sections. As Coe (1978) pointed out as long ago as the 1970s, an understanding of the interface between orthodox and heterodox practices and knowledge over time provides a useful and necessary basis for an analysis of the changes and challenges faced by [CAM and] orthodox medicine in contemporary Western society.

The history of Western medicine dates back to the Greco-Roman society (Coe, 1978). Freidson (1970a) and Coe (1978) believe that this conventionality relates to the fact that the Greco-Roman civilization developed a natural (rather than a supernatural) approach to disease. Porter (1998:50), for instance, affirms that a medical discourse in an elementary form first appeared in ancient Greece. One of the aspects that characterises this era the most is the writings of Hippocrates. Some of the ethical imperatives that underpin the ‘Hippocratic Oath’, for instance, are still used in modern, contemporary medical practice.

In the Oath of Hippocrates, the physician promotes a ‘bedside’ and ‘patient-oriented’ healing approach, characterised by the use of detailed and close observations of patients at the bedside. Through bedside observational methods, the physician would be able to identify certain illness patterns and to make valuable patient’s prognostics. The process of diagnosis was seen by the Oath as an ‘art’, involving the combination of professional experience and training with a holistic approach to the patient (Porter, 1998).

Although the Hippocratic legacy had brought formality to healing (the development of ethics, the scientific base of illness, the codification of medical knowledge, the development of elementary public health practices, etc.), the latter was still characterised by a medical pluralism (Porter, 1998). That is to say, although physicians started behaving as an occupational group, they did not have occupational monopoly. As Porter (1998:54) points out, the healing practice was conducted in the public sphere

by those who called themselves physicians and other kind of healers. Those who wanted to be 'trustworthy physicians' detached themselves from other 'dubious healers', despite their own lack of credentialism. At the time, medical training remained based on face-to-face interaction with charismatic leaders who delivered a 'charismatic teaching' (Cant, 1996).

Despite its scientific progress during the Greco-Roman period, in the medieval era scientifically-oriented medicine was often perceived as heresy and had to struggle to assert itself against the system of beliefs of the time (Coe, 1978; Jones, 2004). Religious scholasticism was powerful enough to ban scientific medical progress. Folk beliefs, Christian philosophies and ancient texts from Hippocrates, Aristotle and Galen were legitimised as medical knowledge, yet they were taught with a devotional character and detached from their methods of inference, observation and evidence. Surgery by physicians was forbidden, since most were clerics who could not shed blood (Coe, 1978; Porter, 1998). The hospital system was under the control of the Church and its personnel. This social, religious and political context had a great impact on the practice and organisation of medicine, which saw little scientific progress during this period.

Medicine advanced considerably in the Renaissance period, with the re-emergence of Hippocratic medicine and the bedside healing system (Coe, 1978). The Galenic dissection and examination of the human body, previously banned in the medieval era despite having already been used in the Greco-Roman period, became once again a legitimised practice. This led to further progress in anatomical and physiological research. As Le Breton (2002) points out, a new perspective of the body had arisen: the body as an 'anatomical object'. Furthermore, new healing drugs and plants were discovered as a result of Paracelsus's pioneering use of chemicals and minerals.

This medical progress would not have happened without specific value shifts that challenged religious authority. One of the most significant changes was the lay protest against medieval mentality and practices. People started perceiving life as something that could be improved, rather than as a pathway to the afterlife. Religious dogmatism was gradually replaced by an interest in scientific methods of observation and experimentation, logic and reasoning (Porter, 1998). As Porter (1998:172) puts it, concerns about the way medicine should be taught, practised, structured and systematised began to emerge.

The 17th and 18th centuries were two great periods of consolidation of medical knowledge, with huge discoveries and inventions. Yet some of these medical advances, such as the microscope, the obstetrical forceps, the clinical thermometer or the smallpox vaccine, were not immediately accepted by and applied to medical practice (Jones, 2004). Anatomical and physiological medicine progressed with Harvey's demonstration of the circulation of the blood, the pump's function of the heart and the description of the muscular system and fractures (Coe, 1978; Jones, 2004; Porter, 1998).

Despite the substantive progress of medicine towards a more scientific practice, there was not yet a single occupation of 'medicine' (Freidson, 1970a), or even a solid view of the medical profession as a collective entity (Kelleher et al., 1994:xi). Instead, multiple healing practices were available in an open medical market place (Jones, 2004; Wear, 1994). As Coe (1978:185) observed, during the 18th century,

Trips to healing shrines were common. In other words, there was a continuation of spiritual cures, a practice of medieval times. Quackery and charlatanism were prevalent. It was during this period that Mesmer practiced 'animal magnetism'³, the precursor of hypnotism, and Gall introduced phrenology⁴ as a 'scientific procedure'.

Porter (1998) and Maple (1992) affirm that the 18th century has been described as the golden age of quackery. In most European countries the quacks became popular. Their popularity, as Porter (1998) points out, was associated with the increasing mobilisation of elite groups in society of which members were well-informed consumers willing to make their own judgements about health and exercise power by demanding all sorts of healing. Furthermore, as Maple (1992:55-56) shows, the British aristocracy of the 18th century opened its doors to a number of quacks for the simple reason that the 'regular' or 'non charlatan' physician (who made up part of a medical elite and was university-trained) could offer nothing more substantial. Porter (1998:285-286) suggests the same idea, saying that the quacks' art was

... to address needs that regulars (perhaps understandably) failed to supply. Thus patent medicines promised to cure cancer, to restore lost youth and potency, or to alleviate conditions like venereal disease, for which patients might be embarrassed to consult the family physician. ... The sick felt no compunction about shopping around for second and third opinions, and made free use of quack,

³ A term coined by the German physician Franz Anton Mesmer which refers to an invisible fluid/force/energy in human body that can be manoeuvred in order to create a hypnotic state.

⁴ It is the science which studies the link between the morphology of the skull and a person's character; was developed by the Austrian physician Franz Joseph Gall.

family and unorthodox remedies as well, adopting a try-anything mentality.

Despite the 18th century being a period of great lay support for ‘medical quackery’, the 19th century presented itself as a transitional period characterised by a change in lay views about scientific medicine, which became more acceptable and gained considerable power, status and authority (Kelleher et al., 1994:xii; Larson, 1977). The late 19th century’s medical practice in particular was quickly characterised by its anatomical and scientific basis and this prompted its definitive consolidation during the 20th century.

Major discoveries and inventions, some of them derived from medicine’s alliance with biology, gave rise to the so-called contemporary biomedical assumptions, such as Pasteur’s and Koch’s germ theory of disease and the doctrine of specific aetiology - the idea that for each specific disease there is a specific cause which is a specific germ, micro-organism or bacteria (Armstrong, 2000; Coe, 1978; Mishler, 1981; Porter, 1998). The rise of bacteriology, in turn, led to new treatments for several infectious diseases, such as anthrax, cholera, tuberculosis and malaria, and to the development of the field of immunology. Surgical progress, in turn, was made possible with the discovery of anaesthesia and aseptic techniques. Although the great pharmacological revolution was in the 20th century, the 19th century also witnessed the development of new drugs and remedies.

From an organisational stance, the 19th century also saw the emergence of specialisation within the medical practice. Amongst other specialities, there were endocrinology, obstetrics, paediatrics, orthopaedics, dentistry, otorhinolaryngology, each of them claiming jurisdiction over specific parts and functions of the body (Coe, 1978; Porter, 1998). As Porter (1998) pointed out, specialisation flourished and achieved legitimacy. Yet it was received with some hostility, particularly from general practitioners, who accused their colleagues of having narrowness of medical practice, overly sophisticated skills and biased medical knowledge.

In Porter’s (1998) opinion, the emergence of medical specialities explained the rise of specific movements in health during the 19th century which protested against the internal ‘fracturing’ of the medical expertise (Gabe and Bury, 1996). The alternative medicine movement soon became very popular and manifested itself in two different

forms: the rise of charismatic healers who provided miracle cures with patent medicines and soon became ‘toadstool millionaires’; and the emergence of healing movements which were hostile to some elements of orthodox medicine and made claims for alternative ways of healing (Porter, 1998:389).

One great illustration of these new healing movements was homeopathy. It was developed by Samuel Hahnemann (1755-1833), a German physician who challenged the orthodox pharmacopeia of the time. Hahnemann developed a different approach to healing based on three main principles: (1) the law of similars (i.e. the view that the treatment of a disease should be done by drugs that lead to symptoms similar to those of the disease); (2) the law of infinitesimals (i.e. the smaller the dose, the more efficacious the drug is); and (3) the law of high potencies and dilutions (i.e. the more a remedy is diluted, the stronger it becomes). Although seen by many as a dissenter, Hahnemann resisted criticism and won great support not only from specific factions of the public, but also from particular sects of the medical profession across Europe and the USA (Porter, 1998).

Despite the spread of these new healing movements, scientifically-oriented medicine continued developing and achieved higher power and status in society. In the late 19th century, the traditional scenario of healing as a free market was transformed by the increased professionalisation of medicine. Medicine started using organisational devices such as professional associations and started developing a close relationship with universities, which, in turn, led to the creation of the ‘medical career’ (Larson, 1977). As Larson (1977:2) says, medicine started becoming dependent on ‘objectively legitimised competence’ and thus became a modern profession.

The professionalisation process of medicine in the late 19th century, alongside its ‘good results’ (Larson, 1977), led medical practice to a qualitative break with the past. A line could be drawn between medicine before and after the late 19th century. Until the late 19th century there was little identity attached to physicians whose title of ‘doctor’ was still missing and then from the late 19th century onwards there was a clear distinction between the university- or formal medical school-trained physician and the ‘irregular’ (Freidson, 1970a) or non-university trained practitioners. The physicians emerged as the ‘well-guarded bastions’ (Freidson, 1970a:11) of healthcare. Yet, as Freidson highlights, solid lay confidence in orthodox medicine was still lacking.

At the beginning of the 20th century medicine became fully professionalised. First, the progress achieved with a set of ‘structural arrangements’ (Winnick, 2006) such as the standardisation of training and medical education, which provided licensed physicians with a level of knowledge and skills more or less equivalent to each other but distinct from that of other healers (Freidson, 1970a; Larson, 1977). Second, with the increasing State interest and involvement in health, medicine achieved self-regulated status and became an officially approved profession to which the State delegated the power over the right to define health and illness and to diagnose and treat illness (Larson, 1977). Finally, the public became more receptive to the physicians’ work and keener to consult these practitioners.

Throughout the first half of the 20th century, the medical profession achieved a higher degree of dominance and control over the division of labour in healthcare than had ever been possible before. Its ‘objective’ view of disease based on an amount of knowledge shaped by a set of universal key assumptions, quickly dominated the healthcare system (Mishler, 1981). This objectification process in medicine, as Bury (1998) called it, became a paradigm which has shaped Western healthcare and has discouraged heterodox notions of health which do not ‘fit’ into the orthodox medical model.

This intolerance of pluralism within medical practice, as Bury (1998) observed, went hand in hand with intolerance of illness within everyday life and with the transformation of health and illness into objects of medical discourse; or, in Conrad’s (2007) words, with the transformation of human problems into medical problems, i.e. the ‘medicalisation’ of human life. From a Foucauldian perspective, the development of this ‘medical gaze’ (Foucault, 1973) promoted an asymmetric and dehumanised doctor-patient relationship, where the patient was subjected to the legitimised expertise of the physician who ignored patients’ views (Foucault, 1973).

Despite having achieved an authoritative position within society, orthodox medicine has been challenged in recent times (Kelleher et al., 1994). Kelleher et al. (1994:xiii) have pointed out that the role of the physician as a medical expert has been challenged both from inside and outside the medical arena. While challenges from inside are evident, for instance, in the rise of managerialism and in the development of nursing, challenges from outside can be found in the revival and increased popularity of complementary and alternative medicine (CAM). In the following section, challenges posed by CAM to the

medical profession will be thus considered.

2.3. CAM and Postmodernity

This section focuses on the development of heterodox healing practices following the mid-20th century and their links to the emergence of wider collective behaviour against the social norms of the time. As previously indicated, the history of orthodox medicine in Western society has gone through periods when heterodox medical practices, after being temporary ‘eclipsed’ (Bakx, 1991), re-emerged and criticised established medicine and made claims about its usefulness. The golden age of quackery from the 18th century and the new healing movements from the 19th century were two great examples. Following these two earlier periods, it has been argued (Cant and Sharma, 1999; Saks, 2003) that during the 1960s and 70s heterodox practices gained a renewed public interest.

Cant and Sharma (1999) have brought to the fore the idea of a ‘revival’ of CAM in contemporary Western society. Saks (2003) also states that from the mid-1960s the use of unorthodox therapies increased significantly in the Anglo-American context. Baer et al. (1998a), through their analysis of the ‘holistic health movement’ in the San Francisco Bay Area, and Eisenberg et al. (1993), through their quantitative studies on lay use of CAM, provide evidence of this revival in the American context, while other authors such as Fulder (1996) and Ernst and White (2000) offer similar analyses of CAM’s revival in the United Kingdom. Fisher and Ward (1994) found the same trend in many European countries (including a brief reference to Portugal), while Kelner et al. (2006), Coburn et al. (1997), Coburn and Biggs (1986) and Baer (2006) have highlighted the rise of interest in these therapies in Canadian and Australian societies.

There are some parallels between the revival of heterodox practices in the 1960s and 70s and in the 18th and 19th centuries: CAM support in the public arena and an increased feeling of lay dissatisfaction and scepticism with the medical orthodoxy (Saks, 2003). Yet, as Saks (2003) asserts, these aspects have been stronger in the ongoing revivalist period than in the previous periods. Saks (2003) goes further and states that the ongoing period notably differs in a crucial aspect from the previous ones: the interest of the State and supranational organisations in legitimising these heterodox practices. By contrast, in the 18th and 19th centuries, alternative healing movements only developed a public content to their jurisdictional claims and were far from establishing legal jurisdiction.

With this revivalist period in mind, Saks (2003) has argued that there was a re-emergence of a 'medical counterculture' in Western society (in Britain and the USA in particular). Although medical countercultural movements were not unique to this period, the strength and intensity of their resurgence was, according to Saks (2003), undoubtedly new. This re-emergence of a strengthened medical counterculture has been seen (Saks, 2003) as the starting point of the ongoing process of CAM legitimacy in Western world.

This medical counterculture was originally developed against normative medical practices and the ideology of the 'medical gaze'. Aspects like 'scientific progress', the materialistic values of the time, and the professional dominance of physicians, came under fire (Saks, 2003; Coward, 1989). Furthermore, medical malpractice, the ineffectiveness of certain biomedical procedures and iatrogenic effects of established medicine were strongly criticised in the public arena. This medical counterculture remains present in Western societies. It has drawn attention to the spiritual and psychological dimensions of health and illness and has objected to aspects of biomedical practice, such as the dehumanised doctor-patient relationship, the view of the physician as an untouchable holy person, and the view of biomedical knowledge as the supreme form of knowledge (Cant and Sharma, 1996c; Goldstein, 2002; Siahpush, 1998).

There have been attempts to explain this medical counterculture as a social movement, i.e. as '... a political process which marginalized sections of a welfare economy employ to represent their interests ... [which are] often concerned with autonomy and identity, and opposition to control and dependence' (Kelleher, 2001:120, 123). The Habermas' perspective in particular interestingly reveals that social movements are the result of an imbalance between 'technical', 'esoteric' knowledge and 'lifeworld' or lay knowledge. Furthermore, they can also help repair the '... link between the different human interests and forms of knowledge' (Kelleher, 2001:121), which can bring about change and can be presented as beneficial to society. Authors like Goldner (2004:711), for instance, have conceptualised CAM as a social movement because of the activism and the collective impact that most CAM practitioners have had on healthcare. As he stated,

[CAM] activists are united through their ideology, which allows diverse and often disconnected individuals to have shared meanings, similar experiences and, most importantly, a connection to something larger than their individual participation.

The perspective of CAM as a social movement takes us to the view of CAM practitioners as a pressure and lobbyist group in Western society. For instance, in the UK Prince Charles is well-known for his enthusiasm and support of CAM therapies. A 2010 press article from *The Guardian* states that Prince Charles has acted as a ‘pressure participant’ (Jordan, 2009) in certain British governmental affairs and

... has been accused of using his privileged position over the last four decades to influence government policies on subjects as diverse as the Human Rights Act, hunting and alternative medicine (Evans, 2010).

In this respect, Jordan (2009:380) gives an interesting account of lobbying in that he regards it as a legitimate part of the political process: ‘Lobbying in this understanding is a (functionally useful) facet of the bargaining networks that characterize policy-making in modern States’. According to Jordan (2009) the boundary between lobbying and ‘policy-influencing’ or ‘policy-negotiating’ behaviour among ‘pressure participants’, interest groups, corporations, intra-government organisations, collective organisations, etc., is often blurred. His (Jordan; 2009:371) expanding definition of lobbying as a ‘... broad process modifying public policy by information-based interaction between groups and organizations and government’ is an attempt to distance his view from the narrow press definition of lobbying and lobbyists.

One could go on to argue that the ‘revival’ of CAM in contemporary Western society, the emergence of a medical counterculture and the perspective of CAM as a social movement have reflected a postmodern ‘state of mind’ (Bauman, 1992) towards health, or a ‘late modern age’ (Giddens, 1991) in health, as it challenges ideas that have been taken for granted, appropriates elements from the past (Saks, 1998) and proposes a renewed pluralism in health choices and treatments. Furthermore, it produces a ‘powerful symbolic antagonism’ between mainstream medical culture, ‘... in the sense of breaking away from consolidated canons’ (Della Porta and Diani, 1999:41) of medical practice. In other words, it presented itself as a problematisation of ‘normative medical practice’ (Della Porta and Diani, 1999:41). As Scambler and Higgs (1998:xi) emphasised, it is common to associate postmodern thought

... with the demise of the – Western, and essentially Eurocentric – project of modernity, condemning its terminally flawed foundationalist defence of universal reason, its rationalist metanarratives, and its failure to deliver – either at all, or at least constructively – on its promises.

What is perceptible in this last quotation is the idea that postmodernity is indeed a condition greatly associated with broader social, cultural and historical changes in society. In the research reported here, however, postmodern thought is analysed primarily in relation to the healthcare domain and to the dynamics between and within health professions. Thus, it excludes wider philosophical interpretations and debates in social theory about this condition. For instance, the move towards a postmodern state of mind has been a process of broader changes in health in Western societies. The rise of consumerism in healthcare and increasing lay expertise (Bury, 1998) are often cited examples. As Bury (1997) observes, the late modern age saw the emergence of a more consumerist relationship between healthcare practitioners and patients, who are often seen as 'equal partners'. Patients have turned into 'lay experts' (Bury, 1998) who are encouraged to express informed opinions and to make informed choices concerning health products and lifestyles. They have contested the absolute truth of well-established forms of expertise such as legitimised medical treatments, pharmaceutical remedies or surgical procedures. As Haug (1976) puts it, since the 1960s and 70s there has been a growing public suspicion that neither the [medical] expertise nor the good will of the professional are to be taken on trust. Some authors have even gone further, suggesting that lay expertise has led to a demedicalisation process in Western societies, i.e. to an incremental opening of previous biomedical issues to non-biomedical practices (Wikler and Wikler, 1991).

Alongside consumer activism and lay expertise, there has been an increasing emphasis on 'health promotion' (Bury, 1998) and on illness prevention recently. For instance, there has been increasing concern over preventative health practices which are expected to improve an individual's physical well-being and to postpone possible illness (Bury, 1998; Williams and Calnan, 1996). This signifies a cultural shift from a focus on illness to a focus on health in Western society. Health is not only an absence of disease but also the outcome of a whole range of social, individual and biological factors. Conrad (1992) called this disposition towards health the 'healthicisation' of society, or the infusion of behavioural and social concerns in previous biomedically defined conditions. So,

This section has reviewed the literature up to the reawakening of a strong medical counterculture and the revival of CAM in the 1960s and 70s. It is now of interest to look at CAM methods of achieving legitimacy from that period onwards. These have been generally understood under the context of professionalisation. We should now turn to a

discussion of this theme and other related concepts.

2.4. CAM's Professional Project

To understand the extent to which CAM practitioners have attempted to professionalise in Western society requires a literature review on the notions of 'professionalisation' and 'profession'. This section therefore starts with some considerations on main sociological definitions of these two concepts. It will then outline the four main dimensions of the professionalisation process of CAM in contemporary society (Saks, 2003).

Some Reflections on the Notions of 'Professionalisation' and 'Profession'

The debate about 'professionalisation' and the nature of a 'profession' is interminable. As Freidson (1994) has observed, 'professionalisation' is, along with the term 'profession' and other derivative words such as 'professional' or 'professionalism', a generic and ambiguous notion. Furthermore, as Evetts (2006) has stated, the operationalisation of some of these concepts can be highly pragmatic, as the debate on the differences between 'professions' and 'occupations' has shown.

As Abbott (1988, 1986) states, there has been a great diversity of theories around professionalisation and profession. For instance, whilst the functionalist tradition focuses on the altruistic service of a profession and looks mainly at professionalisation as a process by which an occupation gains essential traits such as legitimate knowledge expertise (Abbott, 1988, 1986; Parsons, 1954; 1952; Rodrigues, 2002; Wilensky, 1964), more interactionist authors look at professionalisation as an unidirectional sequence of steps by which occupations reach professionalism (Rodrigues, 2002). For instance, Wilensky (1964:145-146), in his remarkable article *The Professionalization of Everyone?*, examines the history of eighteen occupations and concluded that

... There is a typical process by which the established professions have arrived: men begin doing the work full time and stake out a jurisdiction; the early masters of the technique or adherents of the movement become concerned about standards of training and practice and set up a training school, which, if not lodged in universities at the outset, makes academic connection within two or three decades; the teachers and activists then achieve success in promoting more effective organization, first local, then national - through either the transformation of an existing occupational association or the creation of a new one. Toward the end, legal protection of the monopoly of skill appears; at the end, a formal code of

ethics is adopted.

This stance, while powerful, has been heavily criticised by scholars such as Abbott (1988, 1986), who, elaborating a similar case study to the one of Wilensky, argued that the idea of unidirectionality of 'professional life' or the assumption that professions evolve to a given form, usually stronger and richer than their previous one, is misguided. For Abbott, it should be clear that 'professional life' has a variety of directions not only towards strong control and dominance but also towards increasing fragmentation, incorporation, co-option and accommodation, which often means an apparent decrease in professional legitimacy and autonomy. Moreover, some professions often undergo a professional death, while others remain would-be professions and are never fully professionalised. Abbott's idea of the multidirectionality of 'professional life' seems to be especially pertinent to CAM, where incorporation has taken place, as it will be discussed further in this chapter.

Scholars with a neo-Weberian perspective on the emergence of professionalisation in the 1970s and 80s emphasise the power relationships between professions and focus on the notion of professionalisation as the process by which occupations acquire control and autonomy over their work in the marketplace. Freidson (1970a; 1970b), for instance, highlights that when an occupation gains the power and control of its jurisdiction, it is also granted legitimate organised autonomy by the State and becomes a profession. In the same vein, Vollmer and Mills (1966) define professionalisation as the process by which an occupation acquires the right to perform a specific kind of work and to have control over that work performance as well as over the training and the access to it.

In the 1990s, however, Witz (1992; 1990) brought to the fore a new critique of the notion of professionalisation, stating that it is too gendered and generic. For Witz, professionalisation is manifested mainly through gendered strategies of occupational closure (1990). As one can see, Witz's theory about medical professionalisation is greatly built upon the neo-Weberian perspective of professions which sees the latter as engaging in strategies of occupational closure, i.e. as strategically limiting the access of related occupations over the provision of a specialised work in the marketplace (Witz, 1992; 1990).

Jamous and Peloille (1970), in turn, in their analysis of the French medicine, emphasise that the core of a profession and of professionalisation resides in their dialectical forms of knowledge. For them, a profession is defined by its higher levels of indeterminate/technical knowledge ratio. In other words, professions are governed by the 'values of cognitive rationality', i.e. by '... 'means' that can be mastered and communicated in the form of rules' (Jamous and Peloille, 1970:115), in proportion to an important margin of indetermination, i.e. to '... means that escape rules and ... are attributed to virtualities of producers' ((Jamous and Peloille, 1970:112). In the same vein, other scholars have drawn similar distinctions between forms of knowledge work. Freidson (1986), for example, distinguishes between formal (pure, specialised and rationalised knowledge), and informal knowledge (the knowledge used in daily practice which is more pragmatic, judged and influenced by human action). In short, it is precisely due to this dialectical character that professions constantly have to face conflicts of legitimacy.

Lastly, Abbott's (1988, 1986) theory about the meaning of professionalisation and profession is also of great value. In his book *The System of Professions: an Essay on the Division of Expert Labor*, the scholar (1988:20, 86) suggests an alternative theory and focuses the definition of professionalisation on the occupation's control over its work and jurisdiction:

The central phenomenon of professional life is thus the link between a profession and its work, a link I shall call jurisdiction. To analyse professional development is to analyze how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves.

A profession is not prevented from founding a national association because another has one. It can create schools, journals, ethics codes at will. But it cannot occupy a jurisdiction without either finding it vacant or fighting for it.

In short, for Abbott professions exist in a competitive and interacting system. They are linked to a jurisdiction but never in an absolute or permanent way, since professions compete within the system and can challenge each other's jurisdictions from time to time. So, '... every move in one profession's jurisdiction affects those of others' (Abbott, 1988:34). Finally, the system is from time to time challenged by forces, some internal to professions and to the system of professions, such as the expansion of professional knowledge or the attempts of a competing profession to professionalise

itself. These changes, in turn, lead to a disturbance of the system which typically ends with

... the professionalisation or deprofessionalisation of some group or [with the] absorption within the internal structure of one or more existing professions (Abbott, 1988:90).

In this section, the main theories surrounding the concepts of professionalisation and profession have been addressed. These theories are not mutually exclusive but rather constitute a polyphonic discourse, exploring these concepts from different viewpoints. Some pay particularly attention to the gain of traits such as ‘esoteric’ expertise, while others put more emphasis on the support of the State. Others highlight the control over the content of work (i.e. jurisdictional control), while others look mainly at the context of work (i.e. the formation of an organisational structure and the creation of credentialist tactics). Finally, others account for a set of strategies used by occupations in order to draw occupational boundaries and hierarchies (Saks, 1983), an issue which will be further developed later in this chapter. It is now necessary to retain some of the insights given by the professionalisation theories presented above. In light of this, the following sub-section addresses five particular traits or attributes that CAM practitioners have developed through its professionalisation process since the 1960s and 70s in Western society.

Five Dimensions of CAM’s Professional Project

The literature review offered some insights into main dimensions of CAM’s professionalisation project. The structural changes in CAM, the development of abstract knowledge, the support of lay populace, changes in policy-making and the opening of jurisdictional vacancies, are the five main aspects of CAM’s professionalisation. These are attributes that have been recognised by the ‘strategic’ authors as crucial conditions for the success of CAM practitioners’ professional strategies and its subsequent encroachment into mainstream healthcare (Cant and Sharma, 1996a). We will now look at each of them in more detail.

Structural Changes in CAM

Structural changes in CAM relate to the way CAM therapies have organised and represented themselves (Cant and Sharma, 1996a). It has been argued (Wahlberg, 2007)

that the control over their context of work, i.e. the development and transformation of their organisational structure, has encouraged the unification of CAM and has enabled them to become more disciplined. A sociological discussion about forms of credentialism-making is therefore of value. Freidson (1986), for instance, presents two distinct methods of credentialism: the institutional and the occupational. The 'institutional credentialism' is the setting up of (national or international) organisations and associations which receive credentials, usually from the State, in order to operate as legal entities and to establish 'the acceptability of the credentials' they offer to their clients and employers (Freidson, 1986:71-73). Moreover, institutional credentialism also includes the accreditation process, i.e. the formalisation of professional education according to a formal training program usually associated with higher education. This formal training course, in turn, conforms to standards established by a ranking of institutions and degrees recognised by a State agency. And once accredited, an association's course will gain an authoritative status and also comes an important market signal of proficiency and skill (Freidson, 1986:63, 74). 'Occupational credentialism', in turn, concerns the way occupations themselves, through their associations, give a certificate or diploma to a

... qualified candidate, usually after having successfully completed a specific course of study and practice at an accredited professional school and sometimes after having passed an examination. (Freidson, 1986:69)

CAM has moved towards institutional and occupational credentialist models. The case of osteopaths and chiropractors in Britain is a case in point. At the beginning of the 1990s, both sought to unify their array of professional organisations by establishing legislation and forming the *General Osteopathic Council* and the *General Chiropractic Council*. These actions allowed the provision of solid standards of practice as well as the protection of osteopaths and chiropractors' title and jurisdiction. The case of homeopathy in Britain is another great example. The destiny of this therapy in Britain has been placed in the hands of two main associations: the Faculty of Homeopaths, whose members are medically qualified homeopaths; and the Society of Homeopaths, which represents the non-medically qualified homeopaths (Cant, 1996; Cant and Sharma, 1996a).

The attempt to acquire legitimacy through credentialism-making has not been seen solely in Britain. CAM therapies' engagement in institutional and occupational

credentialism has been studied by Kelner et al. (2006), Welsh et al. (2004) and Gilmour et al. (2002) in Canada, for instance, by Norris (2001) in New Zealand, by Launsø (1989) in Denmark, by Mizrachi et al. (2005) and Shuval et al. (2002) in Israel, by Frank and Stollberg (2004) in Germany, by Schepers and Hermans (1999) in the Netherlands and by Nascimento (1998) in Brazil. These studies have suggested that CAM's credentialism-making has been an important dimension of CAM's professionalisation project.

According to Freidson (1986), Larson (1977) or Parkin (1979), for instance, it should be obvious that only with the development of formal institutions of training, will an occupation be able to professionalise. For one thing, these institutions allow the codification, standardisation and technical transmission of a body of abstract knowledge particular to a certain occupation, which, in turn, raises the average quality of its professionals. Formal training and standardised knowledge will be now identified.

Changes in CAM Knowledge

Alongside the attempt to acquire control over the context of work, CAM practitioners have also paid attention to the content of work and transformed the content of their knowledge system. As Larson (1977) points out, from its inception, any professional project involves attempts to formalise and standardise a body of knowledge. This aspect, states Larson (1977), is the basis for achieving internal uniformity and therefore higher status and legitimacy. Yet, as previously stated, there is always a tension between standardised knowledge or 'cognitive rationality' and unstandardised aspects of professional practice.

It is worth returning to Jamous and Peloille's (1970) discussion on the indetermination/technicality ratio. CAM knowledge has traditionally been seen as an indeterminate knowledge (Hirschhorn, 2006), as a charismatic, informal and subjective knowledge based on individual qualities or an individual's 'secret' skills (Larson, 1977). However, current strategies by CAM practitioners to acquire legitimacy and to professionalise have been regarded as attempts to rationalise, standardise and unify their body of knowledge. This has led to a readjustment of CAM's indetermination/technicality ratio. The growing unification of CAM knowledge has reduced the traditional margin of indeterminate knowledge and has added more technical, formal and codified knowledge and training.

The changes to the content of the work of CAM therapies has been noted by authors such as Cant (1996), Cant and Sharma (1996a) and Saks (1996, 1992) in the British context, and by Coburn and Biggs (1986) and Kelner et al. (2006) in the Canadian society. Cant's (1996) account of British homeopathy and chiropractic, for instance, has shown how these two therapies have altered their knowledge basis and practice in order to ensure their survival within the system of professions, develop a relationship of trust with the lay public, and win respect with the medical profession. Cant (1996) showed how homeopathy and chiropractic's attempts to acquire legitimacy and professionalise are usually associated with the creation of professional associations and accredited training courses, which, in turn, have led to the development of scientific knowledge and to a 'tempering of knowledge claims' or a narrowness of scope of practice. Saks (1996, 1992), in his analysis of British acupuncture, has shown how this therapy has redefined its knowledge base from a 'broad-ranging practice centred on traditional Eastern philosophies' to a restrictive practice with a limitative use. Lastly, Coburn and Biggs (1986) have shown how Canadian chiropractic has changed its earlier legitimacy claims and has become, to a certain degree, 'medicalised'.

After reviewing two crucial dimensions of the current professional project of CAM practitioners, it is worth looking now at what Abbott (1988, 1986) suggests are the two key audiences of the legitimacy claims of occupations: the public and the State. According to Abbott, lay and legal support is a valuable resource for the success of occupations' attempts to acquire legitimacy and professionalise. The socio-political context within which CAM practitioners have carried out their professional project will be thus analysed in the next subsection.

The Support of Lay Populace

The reason why Abbott (1988) highlights the power of lay opinion is because he believes it can help an occupation acquire State regulation. So although the analysis of lay preferences is not considered in full in this research, it is still worth mentioning. As Abbott (1988:60) puts it, '... it is ultimately through public opinion that professions establish the power that enables them to achieve legal protection'. So, the process of legitimisation begins when the public acquires an image or perception of a profession, which can be positive or negative. When a profession establishes its superiority in the eyes of a broad public, it is ready to start pressuring the legal system (Abbott, 1988; Larson, 1977).

Most sociological studies of CAM point to a growing lay use of CAM (Cant and Sharma, 1999; Eisenberg et al., 1998; Eisenberg et al., 1993; Ernst and White, 2000; Fisher and Ward, 1994; Fulder, 1996; Sharma, 1995; WHO, 2001, 2012). The impact that lay interest in CAM has had on CAM's legitimacy is clear. As previous research (Saks, 2000a, 2001) has shown, the lay public, once interested in CAM, has pressurised, in many cases successfully, government authorities to enhance political support of these therapies. This political support is easily illustrated through the increasing interest in CAM by Western States, such as the Canadian, the Australian, the British and the American (Coburn et al., 1997; Gilmour et al., 2002; Gort and Coburn, 1988; Kelner et al., 2006; Saks, 2001, 1983).

The crucial role of the State and supranational agencies in the success of CAM practitioners' attempts to gain legitimacy and become more professionalised will be discussed in more detail in the following subsection.

Changes in Policy-Making

It has been said that the support of the Western modern State is an important resource for the success of legitimacy claims of professionalising groups like CAM (Kelner et al., 2006). If we look back to earlier times, mainly up until the first half of the 20th century, we can easily conclude that the interest of Western States in CAM was very low (Saks, 2002; 2000a). A main reason for that was the traditional partnership between the medical profession and the State, with the medical profession traditionally enjoying the privilege of advising the government in relation to a range of health policy issues (Baggott, 2004). As a result, the longstanding climate of rejection of CAM by the medical profession (seen as a privileged occupational group) led the State to override CAM's legitimacy.

However, this scenario has changed since the 1960s and 70s. The greater involvement of the State in the regulation, financing and delivery of medical-care has challenged its old alliance with the medical profession and has questioned the longstanding assumption of the medical profession's autonomy in Western healthcare (Frenk and Durán-Arenas, 1993). Authors like Davies (1987), Baggott (2004) and Klein (2001) have affirmed that, in spite of economic and democratic pressures such as cost containment through competition, 'value for money' in healthcare, and consumers' demand for transparency, the medical profession, although still influential in a range of

health policy issues, began to lose its power as a governmental consultant group in the 1980s. Authors such as Baggott (2004) and Cobburn et al. (1997) explain this decline in terms of the growing emergence of interest groups, such as the consumers or CAM practitioners. These groups have attempted to pressurise the State into legitimising their claims and they have been successful in many cases.

It could be argued that the current scenario of CAM in most Western countries suggests that modern democratic States have been predisposed to a 'citizen-responsive' model of governance, where State actions are driven by 'popular majorities or intense minorities' (Greenberg, 1990:18). Nevertheless, although lay preferences are central to increased State interest in CAM, they blur other key variables upon which State change can also depend. These include: the interests of the State itself and the pressure of other privileged groups in society such as intra-government and supranational organisations; the political parties and parliament; and medical associations and big health corporations such as the pharmaceutical industry or health insurance companies. In light of this, Dunleavy and O'Leary (1987) suggest conceptualising the State as a sort of broker, who despite being constrained by clients, does not just mirror society or follow the public interest in a neutral way; it has autonomy and partisan interests which it tries to accommodate to other organised interests. As Greenberg (1990:29) emphasised,

the State, that is to say, is not the whim of society or economy but an independent and powerful entity capable not only of holding off powerful social forces, but of imposing its own vision and goals of them.

For example, State autonomy can be illustrated by the demands of Western States for the creation of CAM's professional umbrella bodies in order for CAM to achieve higher internal cohesion and standardised training. Usually it has been under the creation of these resources that government authorities have decided to enact the statutory regulation of CAM. This has been witnessed in the case of the British government response to acupuncture and homeopathy, which are the furthest professionalised CAM therapies in Britain, after osteopathy and chiropractic (Cant, 1996; Cant and Sharma, 1996a; Saks, 2001). Similar State demands for CAM's organisational cohesion can be found in other countries such as Canada – in particular with naturopaths, acupuncturists and homeopaths (Gilmour et al., 2002; Gort and Coburn, 1988) –, the USA – with acupuncture (Baer et al., 1998b; Goldstein, 2002; Saks, 2003) – and the Netherlands (Schepers and Hermans, 1999).

The State's autonomy and its vested interests are also illustrated through the State's shared interest in CAM with other key players such as supranational organisations. In its recent document *The World Medicines Situation 2011*, the World Health Organisation (WHO) emphasises the provision of safe and effective traditional and alternative therapies, as well as the provision of a framework for policy to assist countries to regulate CAM, in order to make its use safer, more sustainable and accessible to their populations (Robinson and Zhang, 2011). The European Union (EU) has followed the same pattern. Due to an increasing lay use of CAM by the member States, the EU's interest in CAM (through speeches in the parliament, the creation of advisory panels and consultations with EU's organisations, etc.) has increased (Varga and Kakuk, 2006). It has been said (Varga and Kakuk, 2006) that the turning point in the EU's relationship with CAM was the implementation of two EU programs in 2007 which attempt to financially support CAM research (*Seventh Framework Programme – FP7*), and to emphasise patients' mobility and free choice in healthcare (*Programme of Community Action in the Field of Health 2007-2013*). In summary, one can easily see that both national and supranational policies have supported CAM's revival in a crucial way, widening the opportunities for CAM's professionalisation.

To summarise, Smith (2009:80) states that in order to understand the State, a number of factors should be highlighted: firstly, 'the State is not separated from civil society', meaning that in order to achieve goals such as the implementation of policies, the State needs to build relationships with social groups. Furthermore, the State depends on the interaction and negotiation with those groups which often function as pressure groups by influencing the State and by 'subvert[ing] the intentions of government' (Smith, 2009:80). As Smith (2009:78) states, 'the boundaries of the State are permeable. ... This is because States do not have the ability to control everything'; secondly, there is no unified Western State, as all States delegate governance to numerous governing bodies and quasi-autonomous agencies, i.e. '... arenas of fugitive power operating largely beyond the realm of political deliberation' (Flinders, 2009:321), which are embedded within the policy-making process. These arenas of power, such as the medical associations, weaken the State power as they reduce the State's 'holistic knowledge base' (Flinders, 2009); thirdly, State power is always partial, as it varies across policy, State and time. As Smith (2009:79) puts it, 'States never have complete success for their policies and some policies are not implemented at all'.

The extent to which pressure groups such as CAM relate to the State and influence government policy varies according to the political system prevalent in a country. In 'liberal corporatist' States, for instance, present in Western democratic countries such as Spain, Portugal, Brazil and Greece, the State is sovereign but gives autonomy to self-governing intermediate bodies or 'functional groups' (such as the medical associations) which, although not detached from the State, apply governmental power (Self, 1985). As Self (1985:133-134) states, corporatist States believe '... in a harmonious integration of social interests based upon consensus, and its ideal result would be a society moving co-operatively towards collectively determined goals'. In 'pluralist' States such as Britain or America there is a self-governing system of decentralised institutions which can act selfishly and increase the influence of pressure groups. However, as Self (1985:85) states,

In general, all Western governments have been becoming increasingly fragmented through the multiplication of specialized departments and agencies, many of a semi-autonomous character.

Finally, some authors discuss the State in terms of being modern, postmodern or, as Smith suggests (2009), '*pastmodern*'. For Smith, postmodern and *pastmodern* Western States differentiate from authoritative, hierarchical and sovereign modern States as they are fragmented and have developed new and alternative forms of control over society. However, while advocates of postmodern States often emphasise the loss of power and sovereignty of the modern State due to factors such as the globalisation of society, enthusiasts of *pastmodern* States such as Smith (2009) see the new and alternative forms of State's control as enhancers of State power and sovereignty and as markers of a type of State which is still identifiably modern.

The achievement of professional status, legitimacy and jurisdictional success not only depends on external and social sources such as lay and State support or upon the ability to change jurisdictional claims or professional boundaries as in the case of CAM. Authors such as Abbott (1988, 1986), for instance, state that professions are organised into a system. In order to get into the system, there must be a 'jurisdictional vacancy' which will be contested by other occupational groups. Abbott's key concept of 'jurisdictional vacancy', and its related notions of 'residual areas' and 'subjective character' of professional practice, will now be the focus of the following section.

Jurisdictional Vacancies

This subsection suggests that CAM practitioners' attempts to acquire legitimacy and to professionalise are related to changes within the medical profession itself. Drawing on Abbott's (1988, 1986) systemic theory of professions, this subsection emphasises that professions live in an interactive and competitive system which is from time to time disturbed and readjusted by external forces. These external forces affect individual professions and their 'subjective character', since they can create 'residual areas' and open or close spaces for jurisdiction.

Abbott defines the 'subjective character' of a profession as the 'cognitive structure of its jurisdiction'. That is to say that a profession has a subjective way of defining and controlling the content of its work. This is usually done through three main acts: the diagnosis, which is the subjective definition and categorisation of a problem held by a profession and usually involves a diagnosis classification system; the inference, which is the middle step between diagnosis and treatment, i.e. is the subjective way of professional thinking or reasoning; and the treatment, which is also organised around a subjective classificatory system. In short, with a subjective diagnosis, inference and treatment, a profession defines its 'subjective character'.

From Abbott's perspective, the 'subjective character' of a profession can be challenged by external sources entering the system. Changes in the nature of illness, the considerable rise of chronic, palliative and psychological nature of illness and its impact on medical dominance, have been clear. These changes have led to the creation of a potential clientele with insoluble medical problems and who has been mistreated by biomedicine. CAM in turn has poached weak biomedical jurisdictions or 'residual areas' of non-standard problems which do not match the diagnosis and treatment classificatory systems. Furthermore, CAM has served client groups to whom the medical profession has not been able to provide help.

To conclude, as the literature on CAM's professional project in this section has suggested, CAM practitioners have developed a set of resources in order to acquire legitimacy and to become more professionalised. It should be clear that these resources are closely interrelated with each other. Greater public opinion of CAM has led to an increasing legal support of CAM, whereas the growing legal recognition of CAM has called for the development and transformation of CAM therapies' organisational

structure and for increasing standards of CAM's practice and knowledge. These resources have given CAM therapies the potential to compete within the system of health professions (Saks, 2003). It will be therefore of interest to know the extent to which the Portuguese political context has sustained the success of CAM and the extent to which CAM and the medical profession have influenced State policy in the country.

Whilst focusing on crucial resources of CAM to achieve legitimacy, this section does not account for the recent interplay between CAM and the medical profession worldwide. It does not tell us about the changing relationship between these two stakeholders and does not give us a theoretical framework to analyse CAM practitioners' strategies of impinging on mainstream healthcare. This will be the issue of the following section.

2.5. The Changing Relationship between CAM and the Medical Profession

The focus of this section will be the interaction between CAM and the medical profession since the second half of the 20th century until present time. Although this interaction may be studied from a variety of theoretical perspectives, a neo-Weberian approach will be adopted here. This approach is particularly useful as it analyses the interaction between CAM and the medical profession. It takes into account the boundary changes between professional groups through the use of professional power and political and social pressure, allowing thus a multi-dimensional approach to the professions (Saks, 1983).

According to a neo-Weberian approach, inter-professional relationships are relationships of conflict over power and interests. That is to say, professionalised and professionalising groups engage in a struggle to gain occupational closure through jurisdictional battles (Saks, 1996). These jurisdictional battles are translated into tacit strategies which are used in order to maintain, gain or restrict jurisdictional control. Professions like medicine, for instance, were very successful in professionalising and gaining control over their jurisdiction. As previously stated, medicine succeeded in a way that soon started benefiting from a pre-eminent position among the health professions in Western societies (Gilmour et al., 2002). In the 1960s and 70s, however, the revival of CAM produced jurisdictional battles over certain areas of health. This was the beginning of a conflict between orthodox medicine and CAM.

We should return to Witz's (1992; 1990) analysis of the patriarchal structure of professions and look at her conceptual model of occupational closure strategies, which are derived largely from the ideas of major neo-Weberians such as Berlant (1975), Freidson (1986), Larkin (1983), MacDonald (1995, 1985), Murphy (1988), Parkin (1979), Parry and Parry (1976) and Turner (1985). Although Witz has applied her model to the context of the gendered conflict in the medical division of labour, we should now apply it to the context of the conflict between CAM and the medical profession. Witz's model of occupational closure strategies results in four main strategies engaged by occupational groups: inclusionary usurpation and dual closure strategies, which are primary strategies employed by subordinate occupational groups in response to its outsider status; and exclusionary and demarcationary strategies, which are typical from dominant occupational groups. We will look now at each of them in more detail.

Strategies of Inclusion and Dual-Closure of CAM

In their study of British homeopathy, Cant and Sharma (1996a) identified the engagement of this therapy in strategies of inclusion and dual-closure. As the scholars remarked, non-medically qualified homeopaths, after working for years without a structuralised knowledge system, started to engage in accreditation processes – through the establishment of standards of training and practice taught in recognised courses in accredited colleges. Simultaneously, they dropped their more controversial or esoteric teaching in order to acquire higher recognition by the medical orthodoxy, the State and the lay populace. Overall, the way homeopathy has changed its knowledge system can be seen as a countervailing strategy of inclusion, which is in tension with the dominant exclusionary strategies of the medical profession.

Homeopathy has also engaged in a dual-closure process. On the one hand, traditional homeopaths have demarcated and protected their form of expertise from biomedicine. They claim the safety and efficacy of homeopathic remedies and the legitimacy of homeopathic knowledge (Saks, 1996). On the other hand, these professionals have also tried to draw internal boundaries. They have attempted to increase 'group cohesion' (Kelner et al., 2006) and to standardise courses in different schools, which has resulted in a 'homeopathic identity' (Cant and Sharma, 1996a; 1996b). Furthermore, they have made efforts to ban the potentially dangerous, dubious and non-qualified practitioners from homeopathic practice through entry requirements and accredited training courses

(Cant and Sharma, 1996b).

CAM's closure strategies, however, have provoked counteractions by the medical profession, who have endorsed strategies of exclusion and demarcation from CAM. The next subsection will account for this type of CAM strategies.

Strategies of Exclusion and Demarcation of the Medical Profession

Exclusionary and demarcationary practices of closure are the way dominant occupational groups maintain their monopolistic control over a knowledge system, in order to restrict access to rewards and privileges by outsider groups (Witz, 1992; 1990). The medical profession has acted as a traditional dominant occupational group. Its concern about scientific evidence for CAM has been one of the more effective ways of achieving occupational exclusion and demarcation (Kelner et al., 2004; Gieryn, 1983; Lamont and Molnár, 2002; Lee-Treweek, 2005). Mizrachi and Shuval (2005), for instance, have looked at the prevalence of scientific claims at the institutional level of the medical profession as a way to differentiate the latter from CAM, in Israel. Cant and Sharma (1996a) have shown how the British medical profession has brought to the fore the gaps in the structure of homeopathic knowledge, from the lack of evidence of the effectiveness of homeopathy to the lack of abstraction in homeopathic treatments, which remain based on a subjective rather than on an objective logic. Homeopathic remedies, state the authors, are '... dependant upon the art of prescribing and cannot be taught by formula or rote' (Cant and Sharma, 1996a:582).

Gieryn (1983) and Gieryn et al. (1985) have called this type of strategy 'boundary-work', i.e. the attribution of particular characteristics to a particular professional group (its practitioners, methods, knowledge, values, organisational structure, etc.) for purposes of constructing a social boundary that distinguishes it from other groups. In this sense, the medical profession has attempted to highlight its scientific activities as a way of distinguishing itself from non-scientific professions. As Timmermans and Berg (2003) and Timmermans and Kolker (2004) have shown, the emphasis on the use of scientific activities such as the standardisation of work, clinical practice guidelines, evidence-based practice or randomised clinical trials, is more than an attempt to enhance the scientific nature of medical work: it is a mechanism for the production of professional demarcation or boundaries (Lamont and Molnár, 2002) as well as an attempt to increase medical profession's power and status within the healthcare system.

In a similarly way to Witz's gendered conflict in the medical division of labour, biomedicine's scientific criteria of exclusion are embedded in formal organisations of civil society, such as universities, hospitals, laboratories and clinics. Medical students engage in a long period of schooling and training based on a scientific body of theory. Also, the work in hospitals and clinics is 'aligned with science' (Welsh et al., 2004:219). As Halpern (1992) stated, biomedicine holds a higher degree of influence over the organisation of medical work places as well as enough authority to shape the division of labour within hospitals. CAM, thus, does not fit the prevailing hospital pattern because it is not in accordance with hospital's jurisdictional guidelines. Medical corporations, in turn, such as medical associations or medical journals, are seen as the driving forces behind modern medicine's professional dominance (Saks, 2006:88).

Witz's occupational closure model is powerful in the sense that it pays attention to the power relations and jurisdictional conflicts between professionalised and professionalising groups. Nevertheless, in the specific case of CAM and the medical profession, it presents some limitations, as it does not account for more recent strategies that have been employed by these two groups. On the one hand, whilst it appears that the medical profession still responds to CAM with exclusionary and demarcationary strategies, it has increasingly tended to diminish its resistance to CAM (Kelner et al., 2006; Cant and Sharma, 1996a; Saks, 2003). On the other hand, CAM therapies have changed their jurisdictional claims and professional tactics, to a point that sometimes the medical profession and CAM seem to have undergone a professional convergence, at least in Western countries where empirical studies have been carried out, such as Britain (Cant, 1996, 2009; Cant and Sharma, 1996a; Saks, 2003), the USA (Baer et al., 1998b; Jump et al., 1998; Saks, 2003; Wardwell, 1994; Wolpe, 1985), Denmark (Launsø, 1989), Israel (Shuval et al., 2002), Canada (Coburn and Biggs, 1986; Gilmour et al., 2002; Gort and Coburn, 1988; Kelner et al., 2006; Hollenberg, 2006), Australia (Bombardieri and Easthope, 2000), New Zealand (Norris, 2001) and the Netherlands (Frank and Stollberg, 2004). We now turn to the issue of CAM convergence with the medical profession.

Strategic Alliances

In the countries mentioned above, the medical profession has not only started demanding for scientific scrutiny of CAM knowledge, but has also 'incorporated' CAM (Saks, 1995a). This last action has been classified as a strategic move by the medical

profession. According to Saks (1995a; 1992), by the mid 1970s there was a shift in the medical reception of acupuncture in Britain which signified a move from a strategy of rejection to a strategy of increasing medical incorporation of CAM and of limitation of CAM practitioners to the caring of certain health conditions. Furthermore, the author states that the incorporationist approach pertaining to acupuncture is a kindly way of expressing biomedicine's disagreement with the use of acupuncture's knowledge system. The way biomedicine has attempted to legitimise this therapy is through neurophysiological explanations about the way it works and its delimitation to the management of pain (Saks, 2003; 1996). However, for Saks, the driving force of CAM's incorporation remains the same: professional 'self-interests' in preventing the status and power of the medical profession from being underpinned by an esoteric knowledge system. So for Saks, the medical profession has acted as a chameleon, since whatever its responses to acupuncture may have been, the core reason behind such responses remains the same.

In the same vein as Saks, Callahan (2002) states that orthodox medicine has engaged in an 'accommodating process' where the main goal is to silence CAM and to maintain the subordinate occupational position of CAM as well as the higher status, authority and autonomy of the medical profession in the healthcare system. Baer (2004), in turn, has portrayed acupuncture and homeopathy in the USA as professionalised and partially professionalised heterodox medical systems respectively, which have been granted legitimacy, but at the cost of a subtle process of co-option or absorption by biomedicine. As Saks (2003, 1996) suggested, from 'unorthodox outsiders', CAM practitioners have moved to 'deviant insiders', as they have started integrating mainstream healthcare albeit under biomedical sovereignty.

This alignment of the medical profession with CAM (Winnick, 2006) was anticipated four decades ago by Levy (1966), who had already stated that the biomedical resistance to chiropractors and osteopaths would decrease if the medical profession limited the care of those practitioners to back pain caused by a structural defect of the spinal column. In this sense, for Levy, chiropractors and osteopaths would follow the same trend as other practitioners who offer comprehensive healthcare services but were circumscribed to specific areas of health. And although their functions were independent from those of physicians, they were not always in perfect harmony with them. As he puts it,

Dentists, psychologists, podiatrists and optometrists offer limited care and do not attempt to usurp the role of personal physician. They will refer freely to physicians for diagnosis and treatment of problems outside their professionally defined domain (Levy, 1966:50, 53).

This ‘tacit acknowledgment’ of CAM by the medical profession, as Wiese et al. (2010) labelled it, has been noticed by other studies such as the one of Cant and Sharma (1996a) on British homeopathy. The scholars have shown, for instance, how homeopathy has felt compelled to change the shape and the content of its knowledge as a result of the opposition of the medical profession to part of its philosophical assumptions. As the authors (Cant and Sharma, 1996a) argued, although medical orthodoxy no longer discredits CAM in general, it has adopted an incorporationist strategy, which has meant a loss of freedom of practice and professional autonomy for homeopathy. The medical profession has attempted not only to legitimise homeopathy through scientific knowledge, but also to maintain the complementary and subordinate status of traditional homeopaths, thus retaining the power to decide when a patient should be referred to an alternative practitioner and employ the tasks’ delegation strategy.

Another main target of CAM has been the idea of ‘integrative medicine’, which ‘... in its ideal form refers to a process of collaboration and mutual respect between the systems of medicine involved’ (Wiese et al., 2010). Nevertheless, a number of studies (Shuval et al., 2002) have analysed professional interactions between CAM practitioners and medical doctors in integrative healthcare settings and have suggested that CAM practitioners, although accepted, remain spatially, structurally and symbolically marginalised, and their relationship with medical doctors remains distant and dominated by medical doctors (Broom and Tovey, 2007; Hollenberg, 2006; Wiese et al., 2010). The issue of the segregation of CAM practitioners is an important one, as it accounts for the ‘... distinction between adoption of therapies on the one hand, and recognition of therapists on the other’ (Siahpush, 1999:172).

We should now turn to the next subsection and assess the extent to which the medical profession and CAM have been homogeneous groups in their professional interplay.

Fragmentation of CAM and the Medical Profession

Existing research has stressed that both the medical profession and CAM should not be

considered homogeneous groups, especially when they interact with one another (Baer et al., 1998b; Boon, 1998; Cant and Calnan, 1991; Cant and Sharma, 1996a; Hirschhorn, 2006; Hirschhorn and Bourgeault, 2005; Jackson and Scambler, 2007; Mizrachi and Shuval, 2005). The medical profession, for instance, as Abbott (1988, 1986) remarks, is internally heterogeneous and stratified. On the one hand, there is the medical elite, which is usually personified by national medical councils. On the other hand, there is the medical body. Within the medical body there are internal divisions between medical specialities with conflicting interests and ideologies regarding medical knowledge and practice. There are medical specialities more resistant than others to scientific and evidence-based knowledge and to clinical guidelines. In Hirschhorn's (2006) words, some specialities highlight medicine as both an art and a science. In this sense, medics within these specialities tend to accept CAM more readily than those whose daily practice is closer to scientific and evidence-based guidelines. General practitioners, for instance, due to their wide-ranging character concerning healthcare and illness, have been seen as professionals vulnerable to heterodox practices. At the other extreme, however, is the physician who is a specialist in a particular body organ or physical function and has accumulated very specific, detailed and scientific information which goes beyond that of the general practitioner and is distant from that of CAM practitioners.

With regards to CAM, the desire of some therapies towards a greater professionalisation has led to the establishment of a multitude of professional organisations which often do not agree with the rhetoric of the practice they hold. Since some CAM therapies have modified their knowledge basis in order to converge with orthodox medicine, many CAM practitioners do not accept such knowledge transformation and have employed individualistic attitudes in their practice, such as the disengagement from professional organisations or from long and specialised training. This has created internal conflicts between those practitioners who have resisted professionalisation projects and are concerned with the restriction of CAM practice and knowledge, and those who have attached themselves to the scientific paradigm (Cant and Sharma, 1996a). Baer et al. (1998b), for instance, suggest that despite the tendency of many acupuncturists in San Francisco, California, to engage in a professionalisation project, some have ignored the licensing requirements and have practised clandestinely in back rooms, small offices or at home treating friends or low income clientele.

Another article by Boon (1998) shows how in Canada incoming students with different worldviews – holistic and scientific – experience the training in naturopathy differently. They tend to retain the main philosophy with which they enter the training. This has led to a split in a seemingly homogeneous group between a holistic and scientific interpretation of naturopathy. According to Boon (1998), scientific students are more attached to protocols of treatment, while holistic students are more likely to engage in the caring dimensions of practice. In the same vein, Reddy (2002) has shown how the professionalisation of ayurvedic medicine in the USA has been a pluralistic rather than a monolithic process. And Gort and Coburn (1988) acknowledged fragmentation within chiropractic by identifying ‘the mixers’ and ‘the straights’, i.e. those chiropractors who used adjunctive drugless therapies on which naturopathy heavily relied (for example, hydrotherapy, electrotherapy, thermotherapy, etc.), and those who exclusively focused on spinal manipulation. They (1988:1068) also showed how chiropractic first used naturopathy to scope its own practice and latter on, in the context of fighting for State recognition, changed its relationship with naturopathy by attempting to get ‘... rid of all broad scope practitioners [‘the mixers’]’.

In summary, the relationship between the medical profession and CAM has changed in countries other than Portugal. Both parties have made concessions (Coburn and Biggs, 1986). In Abbott’s (1988, 1986) words, it can be argued that although at the beginning of the battle the medical profession was opposed to CAM, now it has expanded its jurisdiction by moving into new areas of knowledge. And whereas in the past several CAM therapies claimed to be whole alternative medical systems, now they have narrowed their scope of knowledge and defined specific work domains. Nevertheless, it can be argued that whilst some aspects of the interplay between the medical profession and CAM point for a convergence of both the groups, others may rather indicate a divergence. It is therefore of interest to investigate the Portuguese case, by looking at (1) the main strategies used by CAM to promote alternative conceptualisations of healing within mainstream healthcare in Portugal; (2) the extent to which CAM has been incorporated by the medical establishment in Portugal; (3) the responses of orthodox medical doctors to CAM practitioners’ attempts to influence healthcare in Portugal; (4) the extent to which the interplay between CAM and the medical profession has been consensual in Portugal.

The strategies used by the medical profession and CAM therapies to negotiate power

and status within the marketplace, and the role of interest groups such as the State and the lay populace in repositioning the medical profession and CAM therapies in the system of professions and in the marketplace, have been discussed so far. This means that the interplay between the medical profession and CAM has not been isolated from exogenous factors or ‘countervailing powers’ (Light, 2000; 1995), which are constantly interacting with the system of professions and with the healthcare market and end up shaping them. The next section will attempt to show how the system of professions and the field of healthcare are ‘field force[s] of countervailing powers’ (Light, 2000:201).

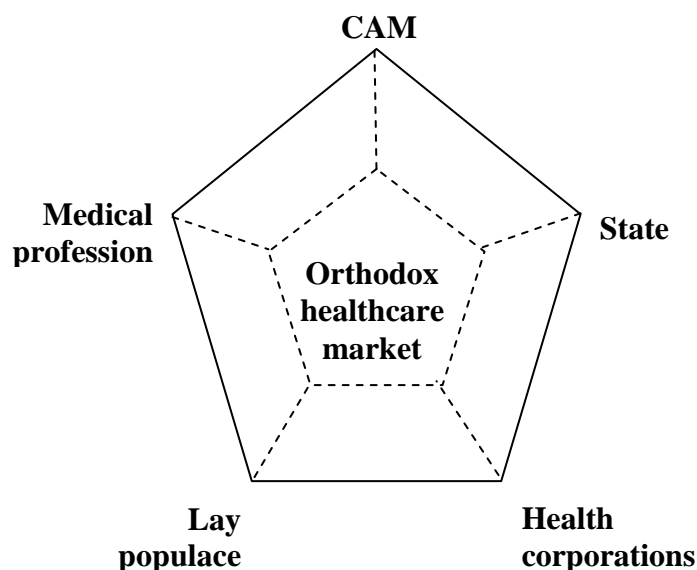
2.6. The Field of ‘Countervailing Powers’

According to Light (1995:26), the concept of countervailing power ‘focuses attention on the interactions of powerful actors in a [the healthcare] field where they are inherently interdependent yet distinct’. That is, countervailing powers are counteractions exercised by certain actors in order to balance centres of power within the market. In the following lines Light (2000:203) gives an insightful definition of what he perceived to be the concept of ‘countervailing powers’:

The central idea is to regard the medical and other health professions as one of several major countervailing powers in society, consisting of the State and employers as payers of healthcare, the medical-industrial complex as producers of products and services for profit, alternate modalities or schools of healing and wellness, and perhaps other parties depending on the country and its sociological character (Light 1995). These parties have different interests, cultures, and goals that are in tension with each other, though significant alignments are possible.

So the concept of countervailing powers is a concept focused on the changes in the market as a result of changes in the power relationships between not only the State and the professions, but also between other stakeholders such as the lay populace and health corporations. The positive aspect about taking such a concept into account is that it allows changes to be traced in healthcare over an extended period of time as a result of the interaction of multiple parties who are constantly bargaining and negotiating power and status within the healthcare market (Light, 1995). Countervailing powers taken into account in this research are represented by the polygon below (Figure 1). Figure 1 illustrates the healthcare market as a product of power bargain strategies between several pressure groups such as the lay populace, CAM, the medical profession, the State and the pharmaceutical industry.

Figure 2.1 Adaptation of the field of countervailing powers from Light (1995)



One could draw a more complex polygon according to the number of parties we believe are involved in power and status negotiation of the healthcare market. For instance, although the analysis of the media or of new information technologies are outside the scope of this research, these sectors would be other powerful stakeholders influencing the balance of power within healthcare markets on the basis of their pursuit for profits, as existing research shows (Silva, 2009; Diack and Smith, 2005; Goldstein, 2004; Gabe and Bury, 1996). So, the countervailing power framework, as Kelner et al. (2004:927) put it, permits us ‘... to specify the interests of the various groups involved and the strategies they are using to promote their particular interests’. Kelner et al. (2004) also alert us to the inequalities of power, status and (socioeconomic) resources and opportunities that exist between the different countervailing powers in the field of healthcare. This aspect leads us to another important notion related to the one of ‘countervailing powers’ which is the concept of ‘alliances’.

‘Strategic Alliances’ between Countervailing Powers

According to Light (1995), the multi-dimensional character of the countervailing parties allows for the creation of alliances between two or more parties of the polygon in order to enhance their power. For example, previous research has drawn attention to the traditional alliance between the medical profession, the lay populace and powerful corporations such as the pharmaceutical industry in frustrating State’s interests in cutting healthcare costs. Van der Geest and Whyte (1989), for instance, pointed out that biomedical power is not solely justified by biomedicine’s scientific evidence and

effectiveness. Despite being based on ‘scientific knowledge’, the scientific evidence for such knowledge is not always as value free as it is purported to be. It is ‘interpenetrated by scientific pressure groups, professional, and socioeconomic interests’ (Degele, 2005:112) which sponsor the dominant ideology of biomedical power. One such stakeholder group is the pharmaceutical industry. Elliott (2004), for instance, has suggested that scientific impartiality in biomedicine has been spoilt by the possibility of biomedicine attaining financial gain in its alliance with the pharmaceutical industry. He reminds us of the pharmaceutical industry’s practice of gift giving to doctors in order to persuade them to follow a market-oriented prescription.

Scholars have also suggested how the pharmaceutical industry has been ‘profit’ instead of ‘scientific’ oriented (Abraham, 2009; Law 2006; Moynihan, 2002; Williams et al., 2009) and has targeted markets that lie beyond medicine’s control (Williams et al., 2011), a process that has been called ‘pharmaceuticalisation’ (Abraham, 2009; Williams et al., 2011). Law (2006:7), for instance, argues that the pharmaceutical industry’s interests in providing good health is not clinically oriented, but rather stimulated by the ‘convenience factor’ of producing ‘drugs that can ease our passage through life with as little discomfort as possible’. In its relationship with the medical orthodoxy and CAM, for instance, the pharmaceutical industry appears to have acted based on its commercial interests. According to Goldstein (2002), pharmaceutical companies had not expressed great enthusiasm for CAM therapies like homeopathy until recently, when the market for homeopathic remedies started enlarging and therefore could no longer be ignored. The pharmaceutical industry is therefore acquiring growing financial interest in homeopathy, as this therapy has stimulated drugs sales (Goldstein 2002) in part due to its broad perception as a non-harmful therapy (Miles, 1998).

Collyer (2004), for instance, has demonstrated how CAM has become ‘big business’ by progressing from a ‘cottage industry’ to a mature market sector, with large national and multinational companies expressing financial interests in a spectrum of CAM products such as vitamins, herbal remedies, acupuncture needles and tables. The author has also pointed out that this marketisation and corporatisation of CAM have been essential to the latter for acquiring legitimacy within mainstream healthcare. Perhaps the most interesting aspect of Collyer’s work is that it challenges the prevailing view of CAM as a profession with mainly altruistic interests in healthcare and uncovers the countervailing nature of CAM practitioners’ actions through its analysis of CAM’s

relationship with the pharmaceutical industry. As he (Collyer, 2004:83) states,

... There is a prevailing view that CAM is somehow divorced from the world of commerce: that CAM services are not commercial transactions but altruistic exchanges associated with holistic notions of health whereby practitioners offer a more ethical and caring approach to individuals and their health needs; and that CAM products are more 'natural' and therefore safer than synthetic, high-technology product. These views are extremely common ... They may be understood best as ideologies which obscure some of the 'less palatable' facts about CAM: the most unpalatable of which may be that this too is a highly profit-directed industry.

In a market-based context, Goldstein (2004) also shows how the corporate sector has capitalised on CAM as the latter can offer potential cost savings. 'Low-cost' alternatives like CAM therapies have encouraged corporations such as private health insurance companies to include coverage to one or another form of CAM. For, as the scholar (Goldstein, 2004:935) says,

For example, having a depressed patient pay out of pocket to use St. John's Wort should be cheaper than prescribing and monitoring a regimen of antidepressants.

In short, this chapter has provided a selective review of the literature on the changing dynamics of key actors within the field of healthcare in countries other than Portugal. We shall now make some conclusive remarks.

2.7. Conclusion

This chapter builds on a selective review of the literature on the changing relationship between CAM, the medical profession, the State and to a certain extent the pharmaceutical industry in Western society. By doing this, it attempts to break away from a fixation on medical dominance (Abraham, 2009) and instead considers the relationships between other key stakeholders. This chapter started with the historical context of the relationship between orthodox and heterodox medical practices over time. It concentrates then on the revival of CAM in the 1960s and 70s and on the emergence of a medical counterculture, which parallels the emergence of new social movements within a postmodern context. The professionalisation of CAM practitioners is then explored. Whilst offering some theoretical considerations about the generic concepts of professionalisation and profession, this section also presented core dimensions of CAM's professional project: structural changes in CAM, changes in CAM knowledge,

the role of lay preferences in legitimising CAM, changes in policy-making and the emergence of jurisdictional vacancies in health, due to the increase of an unnoticed medical clientele with insoluble problems.

The next section went on to examine the changing relationship between CAM and the medical profession drawing on a neo-Weberian perspective. It was shown how the medical profession has engaged into incorporationist strategies and has integrated some CAM modalities into the biomedical practice. Nevertheless, factions within the medical profession concerning its attitudes towards CAM, as well as within each CAM therapy concerning their willingness to professionalise, were addressed. In the last section the scenario of a countervailing power framework where several parties are in constant bargain and negotiation for prestige, power, privileges and status within the healthcare market was presented. This selective review of the literature generated a number of research questions which we should now address.

The Research Questions

The framework adopted here aims to provide a theoretical base for answering the following overarching research questions: *Is the relationship between CAM, the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred?*

The theoretical framework developed also resulted in the formation of seven more subsidiary questions, as outlined below:

- What main strategies have CAM practitioners used to promote alternative conceptualisations of healing within mainstream healthcare in Portugal?
- To what extent has the Portuguese political context sustained the success of CAM practitioners' strategies?
- To what extent have CAM practitioners and the medical profession influenced State policy in Portugal?
- To what extent has CAM been incorporated into the medical establishment in Portugal?
- How have orthodox medical doctors responded collectively to CAM

practitioners' attempts to influence healthcare provision in Portugal?

- How have medical acupuncturists and medical homeopaths responded to CAM practitioners' attempts to encroach upon healthcare provision in Portugal?
- To what extent has the interplay between the medical profession and CAM practitioners in Portugal been consensual?

The next chapter presents the methodology adopted to answer the research questions above.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

In this chapter the research design for this study will be outlined. This chapter is organised into ten main sections. A qualitative, interpretative and case-study approach to answer the research questions arising from the literature review was adopted in this research. This approach is explored in the second section of this chapter. The research sample is then described in the third section. Purposive, snowball and theoretical sampling are presented as my main sampling methods.

Ethical issues raised by qualitative research in general and by this research in particular are analysed in the fourth section of this chapter. The recruitment process is described in the fifth section. The individual semi-structured interviews and the documents were the main methods used for gathering the data. The reasons for having chosen these methods, and the way interviews were conducted and documents were accessed, are explored in section six of this chapter.

The focus of section seven is on the approach to the analysis of the data arising from the interviews and the documents. In section eight, considerations about the plausibility and generalisability of the data are made, while in section nine main constraints of the research reported here are presented. Finally, in section ten, some concluding remarks are drawn.

3.2. Qualitative Research and Case Studies

Sociological research on the changing relationship between CAM and other parties in the field of healthcare has tended to use one or more of the following methods: (1) qualitative research methods such as participant observation in ‘integrative medicine’ settings and individual semi-structured interviews with key-actors such as CAM practitioners, orthodox medical doctors, politicians, leaders or representatives from professional associations; (2) documentary research and library study such as the examination of state-policies, governmental documents, press documents, and professional associations’ documents (legislation, reports from medical associations, government committees and commissions, specialised journals, magazines and

newsletters, websites and conferences' material); (3) formal correspondence with organisations or key-actors in the field of healthcare; (4) informal meetings and discussions with key actors in the field of healthcare who often act as 'informants' and 'gatekeepers' of the research; (5) secondary quantitative data such as statistics on demographic characteristics of CAM users; (6) and primary quantitative research such as questionnaires and postal/telephone surveys about CAM use.

To summarise, both interpretative and positivist paradigms have been present in sociological research on CAM. Quantitative research in sociology of CAM in countries other than Portugal, for instance, has offered important statistical data on the demographic characteristics of CAM actors – the number of biomedical professionals supplying CAM treatments in Western countries or working in collaboration with heterodox CAM practitioners; the sales of CAM remedies by pharmaceutical companies; the number of Western countries developing statutory regulation on CAM; the use of CAM by the lay populace according to gender, age, class, etc. In Portugal, however, there has been a notable lack of quantitative research on the use of CAM by different stakeholders in the healthcare market. When such research is conducted, it tends to be limited to the analysis of the attitudes of the lay populace towards health and constitutes a residual or fringe topic. Such quantitative sociological studies, if well developed, could have provided valuable insights for the research reported here.

Even though quantitative research on CAM has taken place in different Western countries, the qualitative and interpretative approach, however, has held a dominant position in sociology of CAM. Interpretative sociologists have specialised in researching what is meaningful to CAM practitioners, health professionals and state agents about CAM, and the way these actors have attempted to influence the nature of healthcare. Furthermore, they have adopted a 'conflict-based socio-political frame of reference' (Saks, 2001:120) which requires as a methodological tool the researcher's interaction with that socio-political world and its relationship with the subjective meaning of people's actions (Denzin, 2001; Gilbert, 2008; Neuman, 2006; Silverman, 2005, 2004). In light of this, I opted for a qualitative, interpretative research design which, as Seale puts it, '... can reveal phenomena that have not been predicted in advance ... [and] can find things that no one has ever noticed before' (Seale, 2010:76). I will demonstrate this particular point in the course of my thesis with the concepts of 'countervailing powers' and 'camisation'.

In sociology of CAM, qualitative research is usually presented in small scale form and case studies. This is largely because of these sociologists' primary interest in analysing the interactions of CAM practitioners with other actors within the healthcare field in depth. Daly and McDonald (1992:9), for instance, state that:

Qualitative method is indispensable for the study of those aspects of healthcare which depend upon the social interactions between individuals or groups. Its contribution is made primarily in the study of two important aspects of healthcare: a) how patients and healthcare workers interpret their experience of healthcare and the significance which this has for the way in which the healthcare system functions and b) the cultural, historical and political circumstances which influence the nature of healthcare and its delivery.

The research reported here focused on the cases of acupuncture and homeopathy and studied them in detail (see Chapter One for why these two therapies were chosen). In order to answer the research questions arising from the literature review, this research needed to employ qualitative exploration such as the use of (qualitative) historical data, the understanding of the intentions and behaviours of professional groups and other parties, and the interaction with the social setting of such groups. A qualitative and interpretative approach was therefore chosen on the basis of my research questions and my conceptual framework of interactionist and conflict-oriented neo-Weberian perspectives. I was interested in focusing on the subjective aspects of professional life, on the active and creative role of professional groups and individual professionals and on their ability to adjust their actions to the actions of others, an interactionist concern with strong Weberian roots. As Weber (1968:4) stated, 'action is 'social' insofar as its subjective meaning takes account of the behaviour of others and is thereby oriented in its course'. Furthermore, I was interested in the conflict orientation of action and in the competition among different parties such as CAM practitioners, the medical profession, the State and health corporations, which involves a strong identification with Weberian sociology.

After choosing my research design, I concentrated on framing my research sample, to which we now turn.

3.3. The Sampling Frame

This research aimed to be exploratory, qualitative and small scale. Consequently, a probabilistic random sampling was considered unnecessary. As Gilbert (2008) argues, a

probability sample is unrealistic for small scale or qualitative research, since it is extremely expensive, time-consuming and does not fit the small scale study's purpose of exploration, understanding and theory development.

Three forms of sampling, purposive, theoretical and snowball, were adopted in this study. Purposive sampling, Silverman (2005:129) acknowledges, '... demands that we think critically about the parameters of the population we are studying and choose our sample case carefully on this basis. My purposive sampling was guided by conversations with 'key informants' and 'gatekeepers' and by a preliminary analysis of documents such as associations' websites. I was able to establish contact with some key participants such as leaders or representatives from associations and committees. As Robson (1993:142) puts it,

Here [in purposive sampling] the researcher identifies one or more individuals from the population of interest. After they have been interviewed, they are used as informants to identify other members of the population, who are themselves used as informants and so on.

The sampling process of this study was an iterative process which went hand in hand with the data analysis and was shaped by it. This methodological procedure is often referred to in the literature as 'theoretical sampling'. Grounded theorists like Glaser and Strauss (1968:45), for instance, refer to this method as '... the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his [sic] data and decides what data to collect next and where to find them, in order to develop his [sic] theory as it emerges'. Although a fully grounded theory approach was not adopted in this study, some aspects of this approach such as the 'theoretical sampling' were taken into consideration. This means that the sampling was conducted and extended in ways guided by the data analysis and by the theory emerging from it (Robson, 1993:142).

Theoretical sampling is thus related to the selection of groups that the researcher wishes to compare. Those groups should be selected according to their theoretical purpose and relevance, i.e. it should be an outcome of the emerging gaps in the process of generating a theory and of the research questions as well. In other words, since the researcher engages in the development of their own theory from the very beginning of the data collection, they should be guided by that emerging theory process in deciding which

groups they should select. This is why theoretical sampling and purposive sampling usually go hand in hand.

Other participants, mainly the rank-and-file professionals, were contacted by using a snowball sampling. Snowball sampling is usually used for hidden population such as clandestine groups which the researcher has difficulty accessing (Robson, 1993). This was particularly the case with medical homeopaths. The snowball sampling was useful as it facilitated the access to these professionals through other participants who helped me identify potential subjects for the study.

Since the sampling of groups is a process that develops along with the coding and data analysis, the researcher is usually confronted with the decision about the right time to stop sampling groups. According to grounded theorists such as Glaser and Strauss (1968), the answer is ‘theoretical saturation’ and ‘depth of theoretical sampling’. ‘Theoretical saturation’ refers to the non-existence of more additional data or information within an emerging category, the saturation of data or the lack of diversity of data. In the research reported here, I employed saturation of data and I ended my data collection with 41 interviews. The ‘depth of theoretical sampling’ in turn refers to the amount of data that the researcher decides to collect within one category or studied group. Glaser and Strauss (1968) state that the most relevant categories of the study, rather than the less relevant ones, require more in-depth information, i.e. should be completely saturated. We now turn to the sample and describe the three groups being focused on in the study.

The Research Sample

The research sample of the study reported here consisted of a total of 41 participants. The aim of this research was to examine the contemporary relationship between CAM, the medical profession and the State, with a focus on CAM’s interplay with the medical profession. In this light, the research sample was divided into the following three groups as showed in table 3.1.:

Table 3.1. Research sample

CAM	Orthodox Medicine	
Group 1 Traditional CAM practitioners	Group 2 Orthodox medical doctors not committed to CAM	Group 3 Orthodox medical doctors committed to CAM
10 traditional acupuncturists	5 general practitioners	3 medical acupuncturists
10 traditional homeopaths	5 surgeons	2 medical homeopaths
		6 medical acupuncturists who are also medical homeopaths
Total 20	10	11

The sampling criteria for Group 1, the 20 traditional CAM practitioners:

- As table 3.2. (see next page) shows, some of the traditional acupuncturists and traditional homeopaths were selected intentionally on the basis of their key role in the regulation process of CAM. These represent the leaders, some of them also represented national and international associations and organisations related to CAM. Rank-and-file traditional acupuncturists and traditional homeopaths, i.e. practitioners who work full-time and are not directly involved with CAM regulation, were selected by using the snowball method;

Table 3.2. Group 1: Traditional CAM practitioners accordingly to their leadership/rank-and-file position within CAM

Traditional acupuncturists			Traditional homeopaths		
Interview code	Rank-and-file	Leader	Interview code	Rank-and-file	Leader
I6		✓	I12		✓
I7		✓	I13		✓
I10		✓	I14		✓
I1	✓		I17		✓
I2	✓		I19		✓
I3	✓		I16	✓	
I4	✓		I18	✓	
I5	✓		I20	✓	
I8	✓		I21	✓	
I9	✓		I22	✓	

➤ Traditional CAM practitioners in Portugal can be seen as a ‘deviant population’ (Lee, 1999), since they remain professionally unregulated. As Lee (1999) points out, in such cases, selecting participants over a widely dispersed geographical area can drive up costs. I had initially decided to draw the sample on the Lisbon commuter belt area which comprises the metropolitan area surrounding Lisbon, the capital of Portugal, for convenience reasons. However, some key informants and other rank-and-file traditional acupuncturists and traditional homeopaths with a potentially valuable contribution to make lived or worked outside Lisbon, so I ended up extending the sample to other places in the country;

➤ Sampling by gender or age was not undertaken in this research mainly because the emphasis of this study was on the relationship between two professional groups, CAM and the medical profession.

The sampling criteria for Group 2, the 10 orthodox medical doctors not committed to CAM:

- The biomedical specialities chosen, general practice and surgery⁵, cross the boundaries between the holistic and scientific paradigms in healthcare. That is, they differ in terms of the level at which their medical knowledge operates – general/local, indeterminate/technical (Jamous and Peloille, 1970), informal/formal (Freidson, 1986). As Hirschhorn (2006) puts it, within biomedicine some specialities presented as more local, technical and formal than others, such is the case of surgery in relation to general practice;
- As with traditional CAM practitioners, the sampling of orthodox medical doctors was extended to different places in the country. Five rank-and-file surgeons and 5 rank-and-file general practitioners were selected from the public healthcare service, where they were more likely to be found, such as health centres and hospitals, in different parts of the country. These rank-and-file medical doctors were selected through a snowball approach.

Table 3.3. Group 2: Orthodox medical doctors accordingly to their medical speciality

Interview codes Surgeons	Interview codes General practitioners
I34	I37
I35	I38
I36	I39
I44	I40
I45	I41

The sampling criteria for Group 3, the 11 orthodox medical doctors committed to CAM:

- As table 3.4. shows, the majority of these medical doctors (6) were committed to both acupuncture and homeopathy. Among the remaining five, two were committed only to homeopathy while the other three were committed solely to acupuncture. Amongst the medical doctors committed to acupuncture (9), five were accredited medical acupuncturists and four were non-accredited and therefore were not registered by the PMC as ‘medical acupuncturists’. Finally,

⁵ The specific type of surgery was omitted on purpose as this may jeopardise the anonymity of participants.

of these 11 participants, five were leaders of medical acupuncture and medical homeopathy in the country;

Table 3.4. Group 3: Orthodox medical doctors accordingly to their commitment to acupuncture /homeopathy

Interview codes	Accredited acupuncturist	Non-accredited acupuncturist	Practising homeopathy	Rank-and-file	Leader
I25	✓				✓
I26	✓			✓	
I24		✓		✓	
I23	✓		✓		✓
I27	✓		✓		✓
I30	✓		✓		✓
I28		✓	✓	✓	
I32		✓	✓	✓	
I33		✓	✓		✓
I29			✓	✓	
I31			✓	✓	

- The medical acupuncturists and medical homeopaths were selected from private healthcare, where they were more likely to be found, in different parts of the country. In line with the selection criteria for traditional CAM practitioners, some medical acupuncturists and medical homeopaths were chosen on the basis of their key role in the promotion of ‘medical acupuncture’ and ‘medical homeopathy’ in the country; other rank-and-file medical acupuncturists and medical homeopaths were selected through snowballing.
- The medical specialty of these medical doctors was omitted by the researcher on purpose as this may jeopardise the anonymity of participants. It can be disclosed, however, that the great majority of these medical acupuncturists and medical homeopaths were general practitioners.

Having designed my sample, my next step was to acquire ethical approval, to which we now turn.

3.4. Ethics

All qualitative small-scale studies are to some extent intrusive and present ethical dilemmas, as they disrupt participants’ privacy and everyday life (Marshall and Rossman, 1989). Sociologists, for instance, face ethical, and potentially even legal,

conflicts during their research (BSA, 2004). In this respect, a set of ethical principles are necessary in order to guide the conduct of those who embark on research. Christians (2000), for instance, lists two main ethical guidelines which apply to the research reported here. They are ‘informed consent’ and respect for ‘privacy’ and ‘confidentiality’ of the data:

- Firstly, ‘informed consent’, i.e. the participants’ right to be informed about the nature, purpose and consequences of the study in which they are invited to participate. The participants’ agreement to participate in sociological research must therefore be based on full information as well as on an informed choice or voluntary act. Professional associations, like the British Sociological Association (BSA), also state that sociologists have a responsibility to explain clearly to the participants aspects such as the authors, the sponsors and the potential future uses of the research data (BSA, 2004). As Homan (1991) puts it, by informing the participants about all the aspects of the research and by obtaining their consent to participate in the research, the researcher is, in a way, protecting themselves from potential research consequences;
- Secondly, the ‘privacy’ and ‘confidentiality’ of the data, i.e. the protection of participants’ identities and rights from public exposure. The researcher, facing the disclosure of personal and private information, must safeguard the anonymity of participants. According to the BSA’s Statement of Ethical Practice (2004), methods for preserving the privacy of data, such as the use of pseudonyms or interview codes, should be used. Furthermore, when the researcher opts for recording, they should guarantee the confidentiality of the data gathered through this means. One way of doing this is stating that recording material will only be shown to a previously agreed audience;

In this study a separate information sheet with details about the researcher and the research was also prepared and sent in advance to the participants who agreed to be involved with the study. The details included in the form were:

- Who is the researcher?
- How and where can she be contacted?
- What is the research study about?
- What will I have to do and how long it will take?

- What will happen to the information collected?
- What degree of confidentiality is required for this research?

In addition to this, a consent form was prepared and presented to the participants in order to obtain their written consent to participate and to use the information for future research and academic purposes. The topics included in the form were those suggested by Denscombe (2007):

- Researcher's identity;
- Information about the research;
- Expectations about the participant's contribution;
- The right to withdraw consent;
- Confidentiality and anonymity of data;
- Information about the dissemination of the data;
- Signature of the participant and counter signature of the researcher with date.

An English and a Portuguese version of the information sheet and the consent form can be found in the appendix section of this thesis (appendices 1 and 2, pages 304 and 306).

The field research was based in Portugal where, unlike the UK, there is a lack of clear national ethical guidelines for research in healthcare. The research reported here only acquired departmental ethical approval from the Centre for Criminology and Sociology at Royal Holloway, University of London (see appendix 3, 'Departmental ethical approval form', page 308). Thus, it did not require ethical approval by a national research ethical committee or by the College Ethical Committee, as it did not raise any significant ethical questions. The lack of clear Portuguese ethical guidelines for conducting interviews with healthcare professionals, however, increased my level of responsibility to specify in a proper way the research process to the participants in order to enable them to make an informed choice. Moreover, I was always aware that the lack of anonymity is an insensitive research practice and may embarrass and harm the participants. In this latter respect, interview codes instead of participants' names were used and references to places were omitted on purpose in order to protect the personal identity of the participants.

The BSA, the Social Research Association (SRA) and the Portuguese Sociological Association (APS⁶) add to Christians' (2000) ethical guidelines an additional point about the researcher's responsibilities to their sponsor or employer, to their colleagues and academic community and, in a broader sense, to society in general. The research reported here was supported by a Doctoral Grant from the Portuguese Foundation for Science and Technology. This institution's support was always referred to when approaching the participants. Besides all the obligations to sponsors, which should be balanced and should not compromise the research, it is important to safeguard the reputation of the academic discipline of sociology which the researcher represents when carrying out research (Bulmer, 2008). Moreover, the researcher should remind themselves that they contribute to the progress of knowledge in accordance to the highest levels of rigour. Finally, the researcher should think about the potential benefits of their research to society, making use of '... high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings' (SRA, 2003:13). In this study, this 'ethical behaviour' (Bulmer, 2008) was seriously considered before, during and after the data collection.

After acquiring ethical departmental approval, I started recruiting the sample. We now turn to the next section and present the recruitment process of my participants.

3.5. The Recruitment Process

Establishing contact with certain people and gaining access to places proved to be difficult at times because of its disruptive effect on the participants' busy lives and their relative lack of enthusiasm in contributing to a PhD research without direct benefit. With this in mind, developing the support of 'gatekeepers' and key informants was a pre-requisite to gain access and to enter into the social setting of my participants. The data collected during face-to-face, telephone and email conversations with 'gatekeepers', for instance, helped me gain access to other fieldwork participants, settings, events and material. Appendix 4 (page 309) lists the institutions whose members I established contact with.

The role of the 'gatekeepers' however can be problematic. As Walmsley (1993:44) states, 'would they select people with the right characteristics, or would they find people

⁶ Most of the acronyms of Portuguese associations, organisations, etc., referred to in this study appear in its Portuguese original form in order to preserve its authenticity.

who they knew would be co-operative, polite and say nice things?’ Bryman (2008:409) also adds to this that the researcher may run the risk of relying too much on their gatekeepers and ‘... rather than seeing social reality through the eyes of members of the social setting, the researcher is seeing social reality through the eyes of the key informant’. On reflection, the group of traditional homeopaths in particular were keen for me to promote their stance.

I also attended conferences and courses on CAM in the country, organised either by medical doctors or CAM practitioners. This was a very helpful way of approaching some of my participants who kindly agreed to be interviewed. One of the courses with particular benefit for the sampling of medical acupuncturists and medical homeopaths was entitled ‘Complementary and Alternative Medicine – Cascais Summer International School’, held at the Cascais Cultural Centre which I attended from 30th of June to 5th July 2008. This was a course coordinated by a medical doctor and focused on CAM therapies such as homeopathy and acupuncture and on themes such as the complementarity between biomedicine and CAM.

After the recruitment process, I started my data collection. It is to this issue that we shall turn to in the next section.

3.6. The Data Collection

The main methods of data collection in this research were individual semi-structured interviews and documentary material. We look now at each of them in more detail.

The Individual Semi-Structured Interviews

The decision to use individual semi-structured interviews relates to the sort of data that needed to be collected in order to answer the research questions arising from the literature review. According to Denscombe (2007), ‘opinions, feelings, emotions and experiences’, ‘sensitive issues’ and ‘privileged information’ are three main topics for which individual semi-structured interviews usually provide a more suitable method. The research reported here dealt with professionals and other stakeholders’ opinions and beliefs about CAM that had to be analysed in detail. Furthermore, this study covers a current controversial issue: legal and medical legitimacy of CAM within Portuguese healthcare. For this reason, it sought to gather privileged information that would be only

possible to find by interacting with the participants.

Usually, while conducting the semi-structured interviews, the researchers have a topic guide with themes to explore, even if they should be flexible in terms of the order of enquiry. It is to this issue that we shall now turn.

The Interview Topic Guide

The individual semi-structured interviews used in this study were conducted using an open-ended topic guide organised around a number of items. Most of the items linked to a specific section of the literature review. An English and a Portuguese version of the interview topic guides for the three groups of interviewees composing the sample can be found in the appendix section of this study (appendix 5, pages 310). With a few variation in the themes explored, the topic guides covered the following issues:

- CAM professionalisation and regulation
- Strategies to maintain/gain status/power within healthcare
- CAM challenges to the medical profession
- Intra-occupational relationships
- Reasons for choosing a medical speciality/CAM modality
- Biographical data

The specifically designed interview topic guide played a major role in conducting my interviews as well as in helping me focus on the right topics avoiding thus dispersion. After designed my interview topic guide, I started my pilot interviews about which I make now a brief note.

Pilot Interviews

‘Pilot interviews’ were conducted in order to gather preliminary information mainly about the social setting under research. Furthermore, they were used to improve the interview topic guide as well as the research questions and the sampling criteria. Three pilot interviews were conducted, two with naturopaths, one with an osteopath and one with a medical doctor. The pilot interviews were conducted in April 2008 and took place in the interviewees’ home or at their work place. One of the interviewees was a key actor in the field of CAM, while the other two were rank-and-file professionals. The interviews were recorded by using a MP3 audio recorder.

After the pilot interviews, I proceed to the conduction of the individual semi-structured interviews. Some considerations on the interview process will now be made.

The Interview Process

The individual semi-structured interviews conducted by me in the research reported here was a very surprising experience as almost no-one refused to participate (of the totality of interviewees contacted, only one refused to participate). The interviews were conducted between June 2008 and April 2009 and took place in a variety of public and private spaces: consulting rooms in clinics, health centres and hospitals and universities, cafes, public gardens and interviewees' homes and cars. For example, one of my interviews to a medical homeopath was conducted in the back of a car while driving between two towns, and many interviews were conducted in cafes and public gardens. The constraints associated with the use of these spaces to conduct interviews are explored in section 3.9. The average length of the interviews was two hours. All the interviews were taped using a MP3 recorder and later transferred to the computer program Transana 2.12, a computer assisted qualitative data analysis (CAQDAS) software which assisted with the transcription of my digital audio files. The reason to use Transana was related to some training I acquired at a Workshop at the Social Sciences Institute – University of Lisbon in March 2008. I found this software useful to speed up the transcription of my interviews, as it provides keyboard shortcuts and auto-structures the texts we create (Lewins, 2008).

According to the methodological literature (Marshall and Rossman, 1989; Denscombe, 2007), the use of individual semi-structured interviews has some advantages. In the research presented here, they gave freedom to the interviewees to develop their ideas. Yet I always needed to guide and focus the discussion. Besides this flexibility and awareness of the context, other advantages of this method were the 'depth of information', the 'high response rate', and the 'therapeutic' effect caused, as participants tended to enjoy talking about their opinions and ideas to someone who was interested in listen to them (Marshall and Rossman, 1989).

There are, however, some disadvantages of using individual semi-structured interviews as a method of producing data. I experienced some of them. Generally, in-depth interviews are time-consuming, since the data, once collected, need to be transcribed and coded. Furthermore, the physical presence of the researcher as well as the audio

recorder can embarrass both the interviewer and the interviewee and consequently affect the respondents in a way that can bias the data and question the reliability of the research (Silverman, 2010). Added to this is the interviewer's lack of expertise in some aspects surrounding the research topic, which can lead to them asking naïve questions or even to a misunderstanding of the answers to the questions. Yet sometimes a naïve question can lead to a very productive answer and to good interviewer-respondent interaction. I experienced most of these constraints and the present study was certainly influenced by them, yet I tried to minimise their effect.

The data from this research derived not only from individual semi-structured interviews but also from documents. In fact, the interviews were often undertaken alongside an extensive documentary search. We should now turn to the next section and show the way the documentary material was collected in this research.

The Documentary Material

Multiple documents were used as a main source of data. Documents were used because they provide a key source of information for research involving historical and political processes such as CAM statutory regulation in Portugal. Furthermore, they helped me confront and compare the data arising from the individual interviews. The consulted documents included texts such as specialised journals and magazines like the Portuguese Medical Council's Journal (*Revista da Ordem dos Médicos Portuguesa*), books, newspapers, newsletters, letters, papers, memos, leaflets, syllabus, legislation and official reports from governmental bodies. Electronic documents such as websites and audio-visual material like radio interviews and TV debates on CAM were also amply considered. Information was gathered through websites of a variety of professional organisations which are listed in appendix 6 (page 318).

I also looked at supranational agencies' websites such as the World Health Organization (WHO) and the European Union (EU), international organisations websites such as the European Forum for Complementary and Alternative Medicine (EFCAM), and other countries' organisations such as the American National Centre for Complementary and Alternative Medicine (NCCAM). The information gathered from these websites proved particularly useful in comparing the legal status of CAM in Portugal with other Western countries and with supranational agencies' guidelines on CAM regulation.

One of the greatest advantages of using textual documents, according to Denscombe (2007), is that they are usually accessible, cost-effective and durable. One just needs to go online, or on some occasions visit the libraries, to search for official data and government publications. Documentary search was made in different places. Most of the documents were obtained first hand by me from libraries and clinical settings such as health centres. Others were obtained online, sometimes sent via email by participants. Media coverage of the relationship between CAM, the medical profession and the State over the last 16 years was made available to me by some of the participants, mainly in its textual form. These media documents were particularly useful to socially and politically frame my research.

However, although with great advantages, documentary research also faces the researcher with a set of problems that other sources of data do not cause. Access to online or library information is not as clear-cut as it seems. Firstly, access to online information is often restricted. This was the case with some Portuguese medical reports on the regulation of CAM, which could be only accessed by members of the PMC. Secondly, many documents, despite being in the public domain, were difficult to access. Such was the case of the proposals of regulation of acupuncture and homeopathy presented by the ad hoc Committee on CAM regulation in Portugal. I had then to 'negotiate' the access to some information with key-actors who held privileged access to information in the field (Denscombe, 2007:231).

Along with the collection, the process and the organisation of the data, a researcher must make sense of these data and must opt for an approach to their data analysis. We now turn to this issue.

3.7. Data Analysis

This section is divided into two main parts: firstly, an account of how I analysed the interview data will be provided; secondly, a description of the way I analysed the documentary material will be presented.

Analysis of Interview Data

I opted in this study for an approach to the interview data which draws partially on a grounded theory approach. That is to say, I subscribed to specific aspects of grounded

theory, though I did not limit my analysis to only that particular data approach. Grounded theory, as its founders Glaser and Strauss (1968) state, is a strategy for discovering theory from data systematically obtained via social research. This resulting theory, Glaser and Strauss (1968) remark, contrasts greatly with theory which is often logically and deductively developed. In other words, grounded theory has mainly to do with the generation, rather than verification or confirmation, of theory. The aim of this approach is thus to generate a theory which fits the research topic studied. So, the strength of grounded theory is that it is closely linked to the research data and is built upon a strong empirical base.

Analytical approaches such as grounded theory are also concerned with the way the researcher gives form to the data analysis, i.e. the way the data is organised. According to Charmaz (2006), the greatest advantage of grounded theory is that it contains the main practical guidelines about how the social researchers should proceed. Firstly, as soon as we start handling the data, we should start raising questions about them. Secondly, we should begin separating the data through coding and labelling, in order to synthesise, simplify and make comparisons easier. These codes and labels should come from the data themselves rather than from preconceived concepts and hypotheses. Thirdly, we start writing memos about our codes and comparisons and, as we proceed, we are able to interpret the data through analytical categories. As we interpret our findings, our analytical categories will become more robust and more abstract and theoretical. In the end, this process will generate a conceptual framework for our study, which will be an abstract theoretical explanation or a 'grounded theory' of our research (Charmaz, 2006).

Charmaz's (2006) viewpoint on grounded theory draws greatly on what Glaser and Strauss (1968) called the 'constant comparative analysis'. According to Glaser and Strauss (1968:104), the 'comparative method' '... is concerned with generating and plausibly suggesting many categories, properties and hypotheses about general problems'. So, the constant comparative method is a developing process which includes four main steps:

- Firstly, the researcher must code each incident, statement or observation and at the same time compare them constantly with previous statements coded in the same category. This comparative method allows the researcher to find similar and different incidents among the participants, which may give useful insights

and enable further theory construction. During this process, the researcher should engage in memo-writing, since this will help focus on coding and conceptualisation. According to Charmaz (2006), memo-writing is the intermediate step between data collection and theory construction, and is a pathway to theory development, since it retains ideas and notes which can remain relevant until the end of the analysis;

- Secondly, the researcher should develop different levels of conceptualisation by breaking down the categories into their properties, subcategories or dimensions;
- After coding into categories and making the links between categories and their dimensions, the researcher should be able to delineate their theory, i.e. solidify it and, above all, reduce the list of categories to a smaller set of categories. As Charmaz (2006:45) clearly puts it, grounded theory coding makes up the bones of our research analysis, whereas theoretical delimitation or integration links the bones to each other and makes a theoretical skeleton;
- Finally, after delimiting a theory, the researcher should be able to start writing, even if a return to the coded data is often necessary in order to illustrate or validate a point.

I did not fully adopt a grounded theory approach for my data analysis. Firstly, I had engaged in a literature review which led me to synthesise main concepts for my research before starting my data collection. Secondly, I had pre-set a sampling frame prior to data collection and analysis. These are two steps that grounded theorists would develop after or during the data collection and analysis. Nevertheless, I took into consideration specific aspects of this approach, such as the 'constant comparative method'. The interviews data were transferred from Transana 2.12. to another CAQDAS software, the Atlas.ti5 program. I was able to attend two Atlas.ti5 Introductory Workshops, one at the Social Sciences Institute from the University of Lisbon, Portugal, in March 2008, and another one at the University of Surrey, England, in October 2008. The training received in these two workshops allowed me to opt for this program as a tool to build my code-base theory.

Through the Atlas.ti program I elicited a preliminary list of thematic categories inspired by the literature review. I engaged in memo-writing in order to create categories, make relationships between categories and identify gaps in the data analysis. I started developing a conceptual framework alongside the data collection and data analysis. I

adopted an iterative process and ‘a logic of ongoing inclusion of groups’ (Glaser and Strauss, 1968), i.e. although I had previously developed a sampling frame, I did not look at it as definitive. Rather, I simultaneously created and compared new groups that emerged from the data collection, the coding and the analysis. The Atlas.ti program provided me with a preliminary list of around one hundred and fifty codes (see appendix 7, page 320). I then proceeded to analyse the interviews by hand, constantly comparing the data from the various respondents. I used the preliminary list of concepts arising from the Atlas.ti analysis as a conceptual support for my manual analysis.

The advantages of using this analytical approach to the interview data are great. By using this approach the researcher has an ‘open’ rather than ‘blank’ mind on a topic. In other words, the researcher will approach their research topic without a preconceived set of ideas about the meaning and interpretation of their data, even if they focus on a very specific issue or subject. On the one hand, the researcher is informed about a topic but, on the other hand, they should be open to discover new relevant factors contributing to an explanation of that same topic (Denscombe, 2007). Furthermore, while discovering new explanatory concepts and theories, a researcher must be involved in a constant checking of their conceptual and theoretical discoveries against the empirical findings of the research in order to acquire greater rigour and validity of the data. A good example of this was the decision to include in the literature review the concept of ‘countervailing powers’, which is defined in Chapter two. The choice of this theoretical concept resulted from an in-depth analysis of the data, which suggested its applicability to help explain the relationship between CAM, the medical profession, the State and other key actors in contemporary Portuguese society. I shall now turn to the analysis of the documentary material in this research.

Analysis of Documentary Material

As Prior (2003) acknowledged, documentary research should involve not only their rigorous collection but also their interpretative analysis. Documents are not just containers of content. As the author states (2003:4), ‘... a document is a product. ... And, in the ordinary way of things, products are produced – they are produced by humankind in socially organised circumstances’. So, documents are ‘social facts’ (Prior, 2008). They are not neutral but rather manufactured under certain circumstances, contexts or social settings. As Prior (2008) suggests, this means that we should take into account the form of textual materials, the uses of language they display and their link to

genre with different styles and conventions. Documents are assembled under a specific kind of classificatory and categorising system and in specific organisational settings who have their own interests in, for instance, target a certain audience.

As Prior puts it, ‘the initial task is to pay close attention to the question of how documents are constructed as distinctive kinds of products’ (2008:60). For instance, to what extent have CAM associations’ web pages used particular phrases as a way to demarcate themselves from, or include themselves in mainstream healthcare? To what extent have Portuguese official documents used ‘textual formulae’ to generate a documentary reality? Furthermore, to what extent is there a degree of intertextuality among the documents collected? That is, to what extent do different documents share the same format and thus construct a uniform style (Prior, 2008) with specific purposes? To what extent has collective authorship of documents been a rhetorical device for acquiring an authoritative voice in the text? For example, has the PMC shaped its verbal/textual discourse on CAM in order to persuade politicians or consumers? If so, which expressions and vocabulary has this medical body employed in its discourse? Finally, what can one say about supra-State organisations’ guidelines in relation to CAM? How have the WHO’s documents on CAM interacted with documentary material about CAM status in Portugal? I asked these questions of my documentary data, which helped me strengthen my interpretative approach to these documents.

Moreover, documents are not passive items resulting from human agency. As Prior (2003) asserted, the existence of documents can have an effect on people’s actions. This is often the case with official documents such as governmental Acts, for instance. The new Portuguese Act 45/2003 which regulates six CAM’s, for instance, if implemented, would have an effect not only on CAM practitioners’ actions, as they would become regulated professionals, but also on other actors’ actions, such as those from the medical profession, the consumers, the media or the pharmaceutical industry.

Particular attention was paid to the credibility, authenticity and representativeness of the documentary data. For instance, as Scott (1990) asks: how inaccurate is the content of a document? Is the document consulted an original or a copy? If it is a copy, is it a copy of the original or a copy of a copy? Is the document consulted representative of the entire document produced about the topic? These were questions which made me aware of the importance of obtaining genuine, authentic or official documents in order to

strengthen rigour and credibility. In the present research, I was able to acquire the original form of all the documents used.

One big advantage of using documents was the chance to triangulate the information with the data arising from other research methods such as the individual semi-structured interviews. Denzin (1978), who first advocated triangulation in qualitative research, called this technique 'methodological triangulation'. As Webb (2007:455) pointed out, methodological triangulation means using '... different data-gathering techniques applied concurrently to the same problem'. Using triangulation means looking at our subject from multiple points of view in order to improve the credibility of the data. As Neuman (2006:149) says, 'applied to social research, it [triangulation] means it is better to look at something from several angles than to look at it in only one way'. In this study, I triangulated data at the analysis stage by comparing the individual semi-structured interviews data with the data arising from the documentary analysis. This made me more likely to identify different points of view of the subject analysed, and this was a way to cross-validate data and therefore to enrich my data analysis.

The analysis of the individual semi-structured interviews and the documentary material provide the basis for the six empirical chapters presented in this dissertation (Chapters Four to Nine). We should now turn to the next section and make some observations about the plausibility and generalisability of the research data.

3.8. The Plausibility and Generalisability of the Data

All qualitative and small-scale studies, because they tend to be unrepresentative, present a certain number of concerns about data rigor. Social methodologists, however, have argued that the quality of qualitative research lies more on indicators of originality and discovery rather than on positivist ideas of validity and reliability. As Seale (2008:72) puts it, 'perhaps, for example, the quality of a study can be judged according to whether it promotes insight, understanding or dialogue, or in terms of whether it gives voice to particular social groups whose perspective has been hidden from public view'.

On the other hand, there is no point in conducting qualitative research unless the researcher can convince the reader that the data collected was plausible and generalisable. Peräkylä (2008:295), in an article about the reliability and validity in research based on social interaction, asks the usual question: how can findings derived

from small samples be generalisable? The author suggests approaching the problem of generalisability from a different perspective. As he (2008:297) states, ‘the concept of possibility is a key to this. Social practices that are possible ... The possibility of various practices can be considered generalisable even if the practices are not actualised in similar ways across different settings’. For instance in the research reported here, the specific strategies of closure used by the medical profession and CAM practitioners were developed through the use of a small sample and in a particular context. Therefore, they are possibilities. In this sense, they can be generalisable as strategies that can be possibly used by other professionals, i.e. as plausible and believable strategies.

Bryman (2008) develops the issue of generalisability by arguing that qualitative research findings are useful for generalising theory rather than generalising the population of the group studied. This is what Seale (2008) calls ‘theoretical generalisation’, or the judgement of the significance of a new phenomena discovered ‘... by reference to its contribution to some existing body of knowledge or ‘theory’ (2008:26); and Williams (2000) talks about a ‘moderatum generalisation’, which, he says, occurs when the researcher draws comparisons and forges linkages with the findings from other studies. We will see how the next set of empirical chapters, for instance, theorises CAM and places the findings in a relevant theoretical context, making therefore significant use of theoretical generalisation.

In order to enhance the plausibility and generalisability of data, I followed the advice offered by Silverman (2010) and Denscombe (2007) and I put emphasis on the following ways of thinking critically about qualitative data analysis:

- Compare the data, i.e. the interview data collected should be triangulated with data from alternative sources, such as documentary search, in order to obtain a wider perspective of the topic studied;
- Call for ‘comprehensive data treatment’, i.e. the incorporation of all cases of data in the analysis, no matter if they are deviant cases. Thus, the principle here is that all cases increase the knowledge of the researcher;
- Demonstrate openness throughout the research analysis, even if the influence of the researcher’s worldview is most of the times unavoidable in the research process;
- Demonstrate the originality of the data by linking the latter to theory;

I will now turn to the next section where I make some observations about the constraints

of the research reported here.

3.9. Constraints of the Research

This section focuses on the constraints of the research reported here. I believe that such a reflection will illuminate research on CAM relationship with key actors in the field of healthcare. As Peace (1993:34) states, ‘... research is an on-going process of negotiating. In a two- or three-year study you always have to be open to change and re-negotiation. What happens when things do not work out as planned, or when you cannot get access to respondents or settings you wished to study?’

This was the case with the focus group research which I initially planned to carry out in this study. According to Wilkinson (2008:177), focus group research ‘... is a way of collecting qualitative data, which – essentially – involves engaging a small number of people in an informal group discussion (or discussions), ‘focused’ around a particular topic or set of issues’. Within sociology of CAM, focus group has had a complementary role, i.e. it has been combined with other data sources such as individual semi-structured interviews, instead of having been used as a stand-alone qualitative method (Kitzinger, 1994). When compared to individual semi-structured interviews, it should be clear that the strength of focus groups lies in the opportunity to observe participants’ spontaneity and willingness to challenge other group members and to acquire a higher level of participant involvement (Morgan, 1988). My preliminary chapter on methods had considered the conduct of two focus groups, one with CAM practitioners and another one with orthodox medical doctors. After entering the social setting and obtaining the interview data, the idea of conducting a focus group was abandoned for three main reasons: (1) time, place and money constraints; (2) a potential unsympathetic atmosphere between group members, due to the existence of many factions within CAM and the medical profession; (3) the saturation of data arising from the interviews and the documentary research. I therefore believe that the focus group sessions, although useful to examine contrasting or shared views between specific members, would not have added significant data to the research.

The lack of specific quantitative secondary demographic data on CAM practitioners in Portugal was also a constraint of this study. The existence of reliable quantitative data such as the number of medical doctors practising CAM in Portugal, the number of medical doctors practising ‘integrative medicine’ and sharing healthcare settings with

non-medically trained CAM practitioners, the number of medical doctors recommending and referring patients to CAM, the number of traditional acupuncturists and traditional homeopaths in the country, the sales on CAM remedies and products, etc., would be insightful data which could have been complementary to the primary qualitative data collected and would enrich data analysis.

As will be shown in Chapter Five in more detail, CAM policy-making in Portugal has involved the work of many committees appointed by the government and charged with the evaluation and the production of reports on CAM. The new Portuguese Act 45/2003 which regulates six specific CAMs addresses the setting up of an ad hoc Committee (*Comissão Técnica Consultativa das Medicinas não Convencionais*), often referred to in the present research as just ‘the Committee’, which is charged with the study of and providing advice on CAM regulation in the country. The access to the material produced by this Committee was facilitated by a few CAM practitioners and medical doctors who performed as ‘gatekeepers’ in this research. Nevertheless, I believe that this Committee should have been analysed more in-depth. The current ‘status’ of secrecy and confidentiality of the Committee within the Ministry of Health, allied to the State’s holding up of the regulation process of CAM in the country, did not contribute to an easy access to its members, to the Committee’s dynamics and to its documents that have been produced over these years.

The constraints associated with the way the interview-process was conducted is also worthy of a brief mention. Some of the interviews conducted in public spaces resulted in very noisy recordings and thus they challenged the transcribing process. As I checked the recording in the end of each interview, I was able however, to find strategies to deal with the noise interference in the recording, such as making pauses when necessary and avoiding crowded places.

Since CAM legitimacy is a sensitive social issue within CAM circles in the country, the participants tended to behave and talk more naturally in informal conversations with the researcher than during the interview itself. French’s (1993:120) reflections on her research are insightful in this respect: ‘... I have frequently found that they tell me more over a meal or while walking to the railway station after the interview than during the interview itself’. I experienced the same sort of incidents with some of the participants in this study. Triangulation between individual semi-structured interviews and

documents was useful in showing that many interviewees, mainly leaders or representatives of CAM or biomedical associations, did not openly talk during the interview. They were often afraid of compromising themselves even if preservation of confidentiality and anonymity were guaranteed. When the MP3 recorder was turned off, some participants were more open and talkative. This was particularly the case of the medical homeopaths. For example, one medical acupuncturist and medical homeopathic leader asked me several times to turn my MP3 off in order to talk more overtly about the Portuguese Medical Council (PMC). When this occurred, I was able to take immediate notes and write down my ideas after finishing the interview. My general impression was that, because of the fear of Portuguese Medical Council's censure, many of the medical doctors practising homeopathy interviewed were afraid of disclosing their involvement with this therapy. Another example was that of a medical acupuncturist leader who emphasised at the beginning of the interview that he would convey an 'institutional' rather than a 'personal' talk about CAM (Heritage, 2008). This 'institutional' talk was not exclusive, however, to this interviewee but extended to many others, as Chapter Seven and Chapter Eight will further explain.

The research reported here involved the interest groups of the medical profession and CAM practitioners. Conducting research with interest groups, therefore, can be a challenging task. Interest groups are usually groups with high levels of involvement and influence near policy makers. When involved in a research project, they often see the latter as an opportunity to 'sell' their ideas and beliefs and so can exercise persuasion over the researcher. In this study the researcher felt that either the group of CAM practitioners or the group of orthodox medical doctors committed to CAM presented characteristics of interest groups which tried to undermine the autonomy of the researcher. The 'discourse of exclusion' employed by orthodox medical doctors, and the 'discourse of inclusion' presented among traditional CAM practitioners were often used to persuade the researcher. Research methods' books have alerted us to the ethical implications of harm to participants. However, the extent to which persuading the researcher can cause tension to the latter has been less frequently analysed in social research and is deserving of more attention. Young and Lee (1996), for instance, analyse the role of emotions in fieldwork accounts in a number of methodological traditions. Amongst them, I have a particular allegiance with the existential sociology approach. As the authors state, 'existential sociologists tend to emphasise the comfort of the researcher as indexed by feelings of stress, anxiety, the presence of physical

ailments and so on' (1996:100). In most cases I left interviews overwhelmed by feelings of stress and anxiety. I remember an interview with a traditional acupuncturist, for example, to whom I asked if acupuncture is a profession. He reacted and caused me to question my interviewer's role and skills by saying 'what about you? Do you think acupuncture is a profession?' (I7: TA).

My naivety about the topic and in collecting data certainly influenced the way the research was performed. I believe that sometimes such naivety was positive in the sense that it led to useful explanations on the part of the participants. At other times, however, such naivety was negative. For instance, I believe that I should have allowed for the participants to develop certain issues further or I should have ensured the focus on the themes I wanted to explore.

3.10. Conclusion

In this chapter the methodological basis for this study has been presented. It has been argued that the answer to the research questions arising from the literature review needed a qualitative and interpretative approach. The focus of this study is the current relationship between CAM, the medical profession and the State in Portugal. The main research questions addressed here are the following: is the relationship between CAM, the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred? This study therefore concentrates on the strategic actions of CAM practitioners to acquire legitimacy within mainstream healthcare and on the potential changes in the meanings about CAM constructed by medical doctors and the State in Portugal.

Acupuncture and homeopathy have been chosen over other CAM therapies to represent the heterogeneous field of CAM in this study. Two main research groups have been set up: two kinds of CAM practitioners, traditional acupuncturists and traditional homeopaths; and four kinds of biomedical practitioners, surgeons, general practitioners, medical acupuncturists and medical homeopaths.

Individual semi-structured interviews and documents are the main data source of this research. Interview data analysis has been conducted drawing on the constant comparative method. Documents in particular have been approached as products of human agency and so the information they conveyed was analysed as being

manufactured according to specific interests. The triangulation of these two methods has allowed me to deepen the analysis and helped me be more rigorous in my analysis. Theoretical sampling and constant comparative analysis, in turn, allowed me to generalise the data on the basis of their possibility and plausibility.

Data analysis is an iterative process in that it is undertaken alongside extensive data collection and organisation. Data analysis is a very spontaneous process which mainly draws on empirical data but relates the latter with the main concepts from the literature review. The following chapter, Chapter Four, is the first of six empirical chapters which present the main findings of this study and relate them to the literature review. We now turn to the presentation, analysis and discussion of the data.

CHAPTER FOUR⁷

STRATEGIES OF CAM PRACTITIONERS TO CAMICISE HEALTH AND HEALTHCARE

4.1. Introduction

Recent strategies used by CAM practitioners in order to gain legitimacy and promote their own interests within Portuguese healthcare will be analysed at micro and meso levels in this following chapter. A new concept will be introduced in this analysis to highlight the desirable outcome of CAM practitioners' recent strategies within healthcare in the country. This concept is 'camisation', and refers to the process of applying CAM treatments and solutions to everyday human problems (problems that have both been medically and non-medically defined). At a definitional level, this process is similar to that of medicalisation (Conrad, 2007), in that it offers a treatment framework for everyday human problems. Although at the moment camisation and medicalisation seem to run parallel to each other, the former has the potential to reverse the direction of the latter, i.e. to encourage demedicalisation. The new term 'camisation' will thus be elaborated on throughout this chapter, by taking into consideration the case of acupuncture and homeopathy as well as distinct levels of analysis: the conceptual, the institutional and the interactional. Recent strategies used by CAM practitioners in order to 'camicise' healthcare in Portugal will therefore be analysed.

To speak of camisation is to describe the ways in which CAM has become institutionalised in healthcare. A system of professions perspective (Abbott, 1988) will be introduced to emphasise that CAM exists in a competitive system which is disturbed and readjusted from time to time by internal and external forces that can open or close spaces for jurisdiction. Simultaneously, a closure theory of professions will be adopted to show how strategies of closure employed by CAM practitioners can potentially challenge the prevailing healthcare system and the legitimised healthcare provision. Some background on the recent strategies of closure used by CAM practitioners to camicise healthcare worldwide will be provided before the findings are presented.

The literature review on the changing relationship between CAM and the medical profession worldwide presented in Chapter Two showed that the late 1960s was the

⁷ The material from this chapter has been recently published in Portuguese (Almeida, 2011) and a copy of the paper is included in the appendices.

starting point of CAM's revival in Western society (Cant and Sharma, 1999). Such times saw the emergence of CAM practitioners as an occupational group with collective interests which were in tension with those of the medical profession. Fundamentally, CAM practitioners started promoting alternative conceptualisations of healing at a time when biomedicine's tenets began to be questioned (Saks, 1995a; Bakx, 1991). Previous studies (Jackson and Scambler, 2007; Bakx, 1991) have suggested that holism, prevention and clinical pragmatism have been significant conceptual resources or 'knowledge claims' used by CAM practitioners to seek legitimacy within healthcare. These studies have also interpreted these claims as responses to biomedical reductionism in healing, the overemphasis on curative medicine and the ideology of scientific evidence respectively. Furthermore, they look at those claims as being made by CAM practitioners to compensate biomedical imbalances and excesses over time such as *iatrogenesis* (Illich, 1977), 'medicalisation' (Conrad, 2007), emergent 'residual jurisdictional areas' (Abbott, 1988), overmedication and the dehumanisation of healthcare services.

Although significant literature has been produced about CAM's knowledge claims, the analysis of the latter has lacked a proper conceptual framework. One could therefore conceptualise these knowledge claims as 'legitimacy values', which define the character of CAM and help it to acquire jurisdiction (Abbott, 1988). CAM's legitimacy values, however, are of a specific kind: they are 'countervailing values', i.e. values that offset or challenge some aspects of biomedical ideology. The expression of 'countervailing values' by CAM practitioners might thus be seen as a strategy of closure as it has helped define specific work domains and emphasised the need to fill 'jurisdictional vacancies', some of which have been left open by the medical profession (Abbott, 1988). Expressing countervailing values involves '... convincing those outside the profession that its knowledge is valid and useful, actually necessary to society' (Sharma, 1996:165). Furthermore, it denotes a usurpationary type of inclusion, as it entails the countervailing exercise of power in an upward direction (Parkin, 1979; Witz, 1992) on the part of CAM. The emphasis on countervailing values can thus be seen as a main conceptual mechanism to help spread camisation, in which everyday human problems become problems to be framed and treated by CAM.

It was shown in Chapter Two that CAM practitioners have also engaged in many Western countries in other strategies of inclusion typical of professionalising groups.

From a neo-Weberian standpoint, such strategies aim to limit the access of the medical profession to the provision of a specialised work [of CAM] in the marketplace (Witz, 1992; 1990). Previous research has shown that professionalisation, or the process by which CAM practitioners have acquired control and autonomy over work in the market (Witz, 1992, 1990), has been a main strategy of inclusion. In Chapter Two, two main dimensions of the professionalisation of CAM were identified: structural changes in CAM and changes in CAM's knowledge base. Thus, it could be argued that camisation appears to have also occurred at the institutional level in the sense that an increasing number of organisations, educational institutions and courses which adopt a CAM framework to approach human problems have been set up.

Although CAM therapies express countervailing values in relation to biomedicine, they have accommodated a biomedical model and have consequently become biomedicalised (McClean, 2003). Recent research has shown that CAM practitioners have made concessions and has kowtowed to medical science as a strategy to gain legitimacy (Kelner et al., 2006; Coburn and Biggs, 1986). Kelner et al. (2006) have shown how traditional chiropractors and traditional homeopaths in Ontario, Canada, have placed great emphasis on the infusion of basic elements of the biomedical model into their teaching and curriculum. At first glance, this recent alignment of CAM practitioners with biomedical science seems to have contradicted the camisation process. Nevertheless, such an alignment has been analysed as a CAM's strategy (Kelner et al., 2006). By allying themselves with biomedical science and biomedical doctors, CAM practitioners hope to achieve benefits such as higher symbolic status and public legitimacy, which will put them in a better position to camicise healthcare.

Alongside inclusionary strategies, CAM practitioners have also engaged in boundary demarcation. On the one hand, they have sought to draw internal boundaries, by increasing 'group cohesion' (Kelner et al., 2006) and banning potentially non-qualified practitioners through a standardisation of courses. In order to do that, they have employed strategies of exclusion themselves 'to consolidate their own position within a division of labour' (Witz, 1992:48). On the other hand, they have tried to protect their form of knowledge from the biomedical knowledge (Cant, 1996) and to resist the exclusionary and demarcationary strategies of the medical profession.

These strategies have been the main ways for CAM practitioners to achieve

occupational closure and therefore legitimacy within mainstream healthcare in Western countries other than Portugal. They have helped define work domains of CAM within the marketplace and therefore have helped spread the camisation process. It is therefore of interest to know the extent to which CAM practitioners have adopted these strategies in order to camicise mainstream healthcare in Portugal. This chapter thus attempts to answer the following research question: What main strategies have CAM practitioners used to promote alternative conceptualisations of healing within mainstream healthcare in Portugal?

This research particularly focuses on acupuncture and homeopathy. Therefore, emphasis will be given to these two CAM therapies. This chapter specifically explores the data obtained from documents and interviews with rank-and-file traditional acupuncturists and traditional homeopaths and with members of the CAM elite (n=20). We now turn to the investigation of the most prevailing micro and meso level strategies enacted by CAM therapies to achieve occupational closure.

4.2. Strategies Employed to Camicise Healthcare: the Case of Acupuncture and Homeopathy

As in other developed countries, acupuncture and homeopathy have enacted similar strategies of closure in Portugal. These strategies, this chapter will contend, have been chosen over others because they are in line with patients' current interests and with a new trend in national and international health policy: the move towards pluralism. Strategies of inclusion into mainstream healthcare and boundary demarcation will be identified.

Strategies of Inclusion

Amongst the strategies of inclusion, three distinctive strategies were found in both micro and meso levels. They are (1) expressing countervailing values; (2) professionalising; and (3) forming alliances with biomedical science. These are strategies of inclusion into mainstream healthcare and attempts to gain legitimacy, because they are ways of gaining control over jurisdictional vacancies left open, in part by the medical profession. They are thus main contributors to camisation. We now turn to look at them in more detail.

Expressing Countervailing Values

The research reported here shows that strategies which intended to offset biomedical imbalances or excesses over time have been employed by CAM practitioners. One of these main strategies has been the promotion of ‘legitimacy values’ (Abbott, 1988), i.e. central values to which CAM practitioners are committed and which have been left behind by biomedicine. For this reason, these legitimacy values are of a countervailing nature as they have competed with some of the values of modern medicine. Interestingly, all CAM’s ‘countervailing values’ place significant emphasis on a patient-centred model of care. This section will now turn to a discussion of each of these ‘countervailing values’ in more detail.

Holism

At a micro level, both the traditional acupuncturists and traditional homeopaths placed a strong emphasis on holism. Very often these participants claimed that the patients should be assessed holistically, often contrasting this to the reductionism of the biomedical approach to healing. One rank-and-file acupuncturist who had recently graduated in Traditional Chinese Medicine (of which acupuncture is a part) and was providing consultations in a private clinic commented that:

Perhaps being a traditional acupuncturist nowadays means being a doctor fifty years ago. [It] means knowing our patients very well, trying to understand the link between their lifestyle and their illness, their lifestyle, their environment ... all of this ... because it’s important and also I think that being a doctor at present just means treating diseases. (I2: TA)

It is apparent from this statement that being a ‘traditional acupuncturist’ is defined as the opposite of being a ‘doctor’ now. This practitioner attempted to contrast ‘CAM holistic care’ with the biomedical approach to disease which prevails in Portuguese medical practice. He highlighted the social environment of patients not just the physiological and mechanical aspects of the ill body. In other words, he emphasised a view of the disease which ‘is more than the sum of disordered enzymatic and cellular interactions’ (Beresford, 2010). In a way, he attempted to redirect the medical gaze from the patient’s organic body to the patient’s biography (Armstrong, 1979). This move from an emphasis on symptoms to an emphasis on the patient as a whole person was a device used by most of the traditional acupuncturists and traditional homeopaths. Interestingly, it was also a device used in the past by general practitioners (GPs) in their

attempts to survive the early 19th century wave of medical specialism (Armstrong, 1979). As Armstrong (1979:5) showed, by emphasising values expressed by biographical medicine, where the patient moves ‘... from [being] a passive receptacle of organic pathology to [being] the centre of the medical problematic’, the GP could emancipate their general practice from other medical specialisms and secure their role within British medical practice. Now, in the 21st century, CAM practitioners are the ones who have forged new patient-centred approaches to healing which seem to counterbalance some aspects of biomedical ideology.

The shift from an emphasis on the symptoms to an emphasis on the patient was also evident at a meso level of analysis. The way CAM associations define homeopathy and acupuncture, for instance, is illustrative of the importance given to the patient and their environment and context. For instance, in a document accessed through the website of a prominent homeopathic association, the *Portuguese Association of Homeopathy* (APH), homeopathy is defined in the following way:

In homeopathy the results are considered within a wider context than that in allopathic medicine. The ‘simile’-based treatment seems to concentrate more on focusing on and strengthening the healing power of the whole person, rather than on attacking or suppressing a specific symptom. As a consequence, patients often describe homeopathic treatment as having positive effects, not only in terms of the elimination of symptoms, but also in terms of the achievement of higher vitality and better mental and emotional well-being.⁸

This last statement places patients at the core of the treatment and sees them as responsible for their own healing. Furthermore, references to patients’ familial, social and cultural environment are also typical at a meso level. Many leaflets collected from CAM associations included an institutional rhetoric concerned with the importance of the whole person and the environment for achieving a successful healing. For instance, a leaflet from the *International Association of Traditional Medicine and Healthy Activities* (established in Portugal) with guidelines for patients about how to use acupuncture stated:

The main aim of acupuncture is not only healing the body but also the mind. You should adopt new attitudes towards life. You should search for harmony with the others and with the environment in which you live. Avoid arguments. Be tolerant and put aside all the negative and selfish thoughts. Find love and happiness.

⁸ http://aphhomeopatia.weebly.com/uploads/3/4/2/5/3425631/principios_da_homeopatia.pdf (Accessed on the 1st December 2011)

The reference to the patient as a mechanism for legitimating holistic care through an emphasis on the ‘individual’s own responsibility for illness and health through behavioural, attitudinal, and spiritual change’ (Goldstein et al., 1987) was thus very common at both micro and meso levels of analysis. The promotion of holistic care was reinforced numerous times through altruistic statements about how CAM benefits patients. Many of the participants’ accounts conveyed the idea that, in a country where holistic health has become more attractive with the general public but has been underestimated by mainstream healthcare, delivering holistic care can be used, for instance, as a CAM practitioners’ resource to achieve patient retention and to acquire public legitimacy:

It [CAM] has been accepted because the people trust them. The people seek these therapies because they see them working. ... What very often happens is that those who seek us [traditional homeopaths] have already tried a melting pot of therapies, including the conventional ones. And they haven’t got good results. But we can already spot those people who have opted [for consulting a CAM therapy] as a lifestyle ... I’ve got many families, from the great-grand-dad to the great-grand-son who sees the [CAM] practitioner on a regular basis ... (I14: TH)

This last statement also points to an attempt by this traditional homeopathic leader to highlight homeopathy’s patronage by patients who are different members of a family. The reference to a system of patronage networks in homeopathy as allowing homeopathy to grow illustrates some aspects underpinning bedside medicine, such as the community-oriented approach to the patient. In a way, this could also suggest how homeopathy and CAM often remain highly dependent on the patient.

The attempt to legitimate holistic health was accompanied frequently by an emphasis on restorative care and a rebalancing of health. As one homeopathic leader and a representative from the APH pointed out:

[Doctors should] treat first and then send or should send [the patient to the homeopath] to restore what has been distorted. That’s alright if [surgery] was needed but by doing this they [the doctors] have disturbed patient’s sense of equilibrium, you see? And this seems a paradox. They’ve disturbed the balance but they’ve restored it in some way. And so caring should be shifted then [from biomedicine] to natural medicine to assure the patient’s well-being and respect. (I13: TH)

This traditional homeopath put emphasis on biomedical imbalances such as *iatrogenesis* (Illich, 1977). As Illich reminded us as long ago as the 1970s, the adverse effects of biomedical procedures have been growing. This may provide an opportunity for CAM practitioners to encroach upon mainstream healthcare, as one of the claims made by traditional acupuncturists and traditional homeopaths is the ability to ‘rebalance’ the patient and to deal with conditions arising from the adverse effects of certain biomedical measures. This last respondent also suggested the need for a shift from an emphasis on a biomedical approach to an emphasis on a CAM approach to the patient care process, and therefore the camisation of health. Finally, this last statement encapsulates the idea of the promotion of homeopathy as a complementary therapy and conveys the suggestion that this therapy makes use of gentle treatments to restore patients from invasive biomedical procedures such as surgery. So, one can denote here an attempt of this traditional homeopathic leader to camicise iatrogenic effects derived from the medicalisation process of human problems. In this sense, the last statement emphasises camisation as a complementary and therefore parallel option, rather than an alternative or oppositional process to medicalisation.

The claims for holistic health often included an emphasis on humanised care, in contrast to modern medicine which, as Habermas (1984) stated, excludes ‘lifeworld communicative action’ between the doctor and the patient. This is illustrated by the following statement from a rank-and-file traditional homeopath, who worked for a pharmaceutical company before fully committing to homeopathy and naturopathy:

The *dehumanisation* of allopathic medicine disappointed me a lot. I totally refuse seeing a patient as a set of clinical analyses, of scannings with a diagnosis and a label. ... So, the patient turns into a superficial thing which is thrown inside a folder. The top of this is when allopaths, when they want to dig and to build a relationship with the patient, they won’t be able to if they happen to be in a public institution. Why? Because currently the less time they spend with the patient, the more profitable they are. I usually spend rather than waste my time with the patient. (I21: TH, my emphasis)

One can see here the attempt of this traditional homeopath to lay jurisdictional claims on ‘humanised care’ and to show how this has been a much neglected area within allopathic medicine. First, humanised care is tacitly justified through the references made to the excesses of biomedicine and the medical profession, such as dehumanisation, scientific and technological reductionism and objectification of the patient. Second, Portuguese health policy’s constraints regarding the length of patient

consultations in the public healthcare service, like in health centres, are blamed for compromising humanised doctor-patient relationships. It seems therefore that the claim for humanised care represents a countervailing value as it emphasises a return to a broader sense of ‘care’ which has been lost by conventional healthcare over time. Also, respondents claimed that humanised care is something that would certainly be well-received by those patients who are keen on dialogue during a clinical encounter.

In summary, holism has been used as a countervailing value in that it highlights the shift from an emphasis on the symptoms to an emphasis on the patient and their environment. Furthermore, holism has been evident at both micro and meso (institutional) levels and has been applied not only conceptually but also in practice by traditional acupuncturists and traditional homeopaths. Furthermore, expressing countervailing values such as holism appeared to have been in line with patients’ interests, which are likely to sustain support for holistic care.

Preventative Care and Health Promotion

Along with holism, preventative care and health awareness were other significant countervailing values expressed by CAM practitioners. Both traditional acupuncturists and traditional homeopaths underlined the importance of preventative care and health awareness. Yet, for the most part, preventative care remained mostly an ideal. As one traditional acupuncturist leader and a representative from one of the most popular associations of traditional acupuncture in the country – *Professional Association of Acupuncture and Traditional Chinese Medicine* (APAMTC) – clearly put it, illness prevention depends not only on practitioners and patients’ changing attitudes, but also on structural factors, such as the delayed statutory policy on CAM in the country:

Acupuncture has been spreading and spreading and currently it’s quite easy [practising it]. [Yet] not in the way we would like to practise though, which would be preventing ... The goal of Chinese Medicine is preventing and not treating. As we [CAM practitioners] haven’t been able to legalise our status, I mean, the Act [45/2003] is already approved but there is no regulation yet, the result is a lack of State insurance and coverage, there is nothing basically, and this has prevented people from opting for CAM more often ... look, they only opt for CAM as a last resort. And this is bad. (I6: TA)

The reference to the State as a main source of CAM legitimacy in the country is significant in this quotation. Specifically the Portuguese State is blamed here for not fostering the preventative care that could be delivered by acupuncture. In the same vein,

rank-and-file traditional acupuncturists associated chronic illness with a deficient preventative healthcare system and claimed that Traditional Chinese Medicine (TCM) is believed to be more preventative than curative. The next statement illustrates how this participant defined 'preventative care', through the emphasis given to health education and health awareness as two potential factors in encouraging preventative care in the country:

JA: So, when should we see the acupuncturist?

I: Always. Even when we haven't got ill yet. Particularly when we haven't got ill yet. When we're not ill yet, that's the right time to see the acupuncturist... the Chinese Medicine [therapist] ... This is the main message [I give to patients]. (I3: TA)

This respondent acknowledged that being preventative means consulting the acupuncturist in a healthy condition and in the absence of disease. His comment implies that promoting preventative care may involve changing long-standing lay attitudes towards health, as patients tend to see the doctor only when they feel ill. In a way, this respondent attempted to shift 'the direction of imputation of sin and moral failure in relation to not only illness, but lifestyle lapses' (Lowenberg and David, 1994:589), which, in turn, may represent a shift in the opposite direction towards medicalisation. One can see the attempt of this respondent to make the 'healthy person' a main target of intervention of CAM. By claiming preventative care, CAM practitioners would acquire jurisdiction over the 'healthy person' who would engage in constant surveillance (Foucault, 1973) or perpetual care. This emphasis on a salutocratic society '... in which health is the reigning value' (Lowenberg and Davis, 1994:595), has had as a consequence, as Lowenberg and Davis (1994) proposed, broadened the pathogenic sphere, by extending it to everyday problems such as lifestyle change and placing it under CAM scrutiny.

Another traditional homeopathic leader and representative from the *Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas Não Convencionais* (CNNET), an aspiring CAM Council which was set up in 2008 with clear regulatory, protective and disciplinary ambitions over CAM, redefined CAM as 'natural medicine' and associated its increasing status in the country with changing lay attitudes towards health:

Sticking [to CAM] means understanding that there are other ways of healing which can be exclusive or complementary used alongside the so-called conventional, allopathic medicine and at the end of the day it's all about having a better quality of life, I mean, what people think about quality of life, better diet, exercise, mental well-being, which really are main tenets of *natural medicine*, and now people keep thinking about them. They [the lay public] have not just agreed with that. They [the lay public] are also taking action. And this means a qualitative improvement in public awareness [of health]. (I17: TH, my emphasis)

In this quotation the CNET representative is promoting the need for people to have a healthier lifestyle and therefore to take a more preventative rather than reactive approach to disease and illness. According to him, the unfinished statutory policy on CAM has restricted patients' access to 'natural medicine', and in turn, has made it difficult to implement preventative care (a core element of CAM) into mainstream healthcare.

In summary, paralleling claims about holism, preventative care is clearly an area to which traditional acupuncturists and traditional homeopaths have laid jurisdictional claims and therefore have attempted to camicise, at least at the conceptual level. In the same way as holism, preventative care and health awareness constituted 'legitimacy values' in a countervailing form, in that they shift the emphasis from curative to preventative measures. Their expression could be seen as an attempt to counterbalance excesses of biomedical ideology - such as the overemphasis on curing disease - by proposing a more preventative healthcare service. This process of highlighting the importance of health and well-being by raising people's awareness of the risks to their health and by emphasising the need for them to adopt healthy life-styles, constitutes what previous authors (Conrad, 1992) have called 'healthicisation'. 'Healthicisation' has been conceptualised as the process by which 'behavioural and social definitions are advanced for previously biomedically defined events (e.g. heart disease)' (Conrad, 1992:223). In the analysis developed here, 'healthicisation' appears to be entwined with camisation. One could argue therefore that 'healthicisation' has become a key element of camisation. It can also be seen as a countervailing value as it has helped traditional acupuncturists and traditional homeopaths show they are necessary within the health marketplace.

In contrast to holism, however, preventative care and health awareness seem to have been more difficult to implement in practice due to issues such as the lack of political support, which if acquired would have helped broaden preventative attitudes among the

people. We now turn to a third countervailing value which is promoting alternative healing.

Alternative Healing

There is strong evidence that providing alternative care in certain 'residual medical areas' has been a main strategy for CAM practitioners to seek legitimacy. For example, one of the reasons why acupuncture is at the forefront of CAM's attempt to self-regulate in many Western countries is because of its promotion as an alternative to the biomedical management of pain, which often deals with pain chemically and not uncommonly with minimal success. In this sense, promoting more 'gentle alternatives' to certain biomedical procedures is a clear example of a compensatory strategy used by CAM practitioners in order to achieve legitimacy. For example, although many acupuncturists refused to narrow acupuncture's use to specific conditions, they often mentioned palliation as a main area of intervention. Pain management in cases of rheumatology and lower back pain, for instance, were referred to by the following rank-and-file traditional acupuncturist:

Imagine somebody with sciatica or a lower back pain ... what do they usually get from the hospital? [They] will do [clinical] analyses, they may have to do loads of other things. An x-ray, perhaps a CT scan, and then you'll take a cocktail of *Voltaren* and *Relmus* and many other things. And a reasonable acupuncturist can find out if it is a lower back pain or sciatica just by observation and palpations. And with four or five needles [the practitioner] can make the patient feel the pain has been relieved. And after three, four days, the patient should get better. (I5: TA)

This quotation is very interesting as it contrasts different diagnoses and solutions to medical problems such as lower back pain. On the one hand, medicalisation of lower back pain is mentioned through an emphasis on high-technology medicine and invasive chemical medication. On the other hand, an alternative to medicalisation, i.e. camisation, is offered, through an emphasis on more gentle and traditional ways of diagnoses, such as observation and palpation, and of treatment, such as acupuncture needles. This last statement also shows that the camisation of lower back pain is being reconfigured at a conceptual level and also at the agency level.

Although traditional acupuncturists often claimed jurisdiction over palliative care, they also mentioned other conditions for which acupuncture should be legitimised as an

alternative. Infertility, migraine, smoking, drug and alcohol addiction, depression and weight loss were also often referred to as possible areas for which acupuncture could be used, and were thus identified as potential areas for camisation. One rank-and-file traditional acupuncturist, when asked about the main successful areas of treatment with acupuncture, commented that:

To be more specific, for example ... [acupuncture is successful] for migraines, infertility, hmm... at the moment acupuncture has been much advertised in the media to treat infertility. They [fertility treatments] take so long, but they work and I can say that from experience. I've already got many [patients who are] pregnant women. ... And in [cases of] addiction. Drug addiction, alcohol addiction, mental illness, depression, essentially depression, many depressions, emotional aspects, anorexia and the most common at the moment is using acupuncture to take off weight. Reduce the appetite by using specific acupuncture techniques. Hmm ... acupuncture would be worthwhile in any area, in any clinical area, I think. (I1: TA)

Although this participant ended by acknowledging acupuncture as a wider therapy, she made jurisdictional claims over some medical conditions traditionally dealt with by biomedicine. Not surprisingly, these conditions tend to be residual biomedical areas for which biomedicine is not an effective solution. As Abbott (1988:44) has suggested, residual (biomedical) areas are a 'standard site of inter-professional poaching', since their diagnosis, treatment process and outcomes are all problematic and so the jurisdiction over them can be vulnerable to attack.

The attempt to provide an alternative system of healing to biomedicine in residual medical conditions was also evident among traditional homeopaths. Skin problems and children's persistent throat infections, for instance, were two residual medical conditions often referred to by these practitioners as vulnerable to what has been designated by camisation. However, traditional homeopaths generally showed more resistance in redefining the boundaries of their practice than traditional acupuncturists. For the traditional homeopaths, providing alternative care means confronting the disease in a way that is contradictory to that of biomedicine. They legitimised homeopathy as a 'medical system' totally distinct from the biomedical one and emphasised the useless and invasive nature of some biomedical procedures in treating certain medical conditions. As one rank-and-file traditional homeopath put it:

And then I was fed up of getting involved with 'anti' medication. ... And then I found myself doing an inventory of the therapeutic weapons that allopathic

medicine's got. *Besides the antibiotics*, which solves some situations when they can though, by killing the infectious bacteria, I cannot see any more remedies solving any other situation. All of these 'anti' remedies they don't really solve the problem. They just destroy the symptoms. (I21: TH, my emphasis)

The efficacy of medicine was often criticised by the majority of traditional homeopaths. Statements about the invasive and 'anti' nature of biomedicine were often cited. The biomedical ideology of healing where 'an opposite cures an opposite' is often criticised and opposed to the homeopathic ideology of 'a similar cures a similar'. Furthermore, this respondent questioned the therapeutic superiority of biomedicine by referring to the antibiotic as its only real curative measure. These claims, although amplified, are reflective of the question posed by Nicholls (1988) of how biomedicine came to enjoy a mainstream position in the healthcare system with such little therapeutic efficacy. In response to this question, Nicholls argues that the power and status accorded to biomedicine are less a reflection of the therapeutic superiority of biomedicine than of the achievement of an expert knowledge over time which has been standardised and mechanised in order to be rentable.

In summary, alternative healing in residual medical areas represents a countervailing value expressed by the respondents in that they aimed to appropriate problematic jurisdictions and fill jurisdictional spaces left open by the medical profession. Furthermore, alternative healing implies using CAM definitions, treatments and solutions in medical areas where the degree of medicalisation at the agency level has been weak and therefore where opportunities for poaching and for camicising are greater. This aspect is also suggestive of camisation as an alternative rather than complement to medicalisation. Furthermore, it evokes a potential consequence of camisation: the demedicalisation process of certain health problems, as some previously medical interventions to health problems 'are no longer deemed to be appropriate solutions' (Conrad, 1992:224), and can be usurped by CAM.

Finally, constant references to clinical pragmatism seemed an attempt to shift the emphasis on scientific evidence to an emphasis on pragmatic ways of conducting the healing process. This countervailing value will be analysed next.

Clinical Pragmatism

Quah (2003), in her research on Traditional Chinese Medicine in Singapore, states that

this therapy's practitioners tend to adopt an '*ethos* of pragmatic healing' as a temporary response to its incongruity with the ethos of science. Adopting a pragmatic *ethos* or disposition towards healing means legitimating an approach to healing which is less informed by scientific evidence than by clinical experience and clinical routine. This *ethos* is clearly illustrated by an acupuncturist leader who claimed a 'clinical transdisciplinarity' which he defined in the following manner:

Medicine for me is the capacity to get results, doesn't matter what the technique being used is. It can be *dancing around the person*. It's the cure. The cure or the patient's progress. So, this is what medicine is. So, it doesn't matter if it's *homeopathy*, or *something else*, or the merging of ... Look, I agree with transdisciplinarity ... Look, if somebody likes *showing off in a religious way* or *doing a roly poly*, what's the matter with that? If they're happy, they should keep doing it. So, it doesn't really matter, that's it. (I6: TA, my emphasis)

This quotation illustrates very well how exploratory this respondent's discourse is. For, dance therapy, homeopathy, religious healing or movement therapy are used to validate and legitimate non-scientifically based healing paths. A significant clinical pragmatism is therefore present in this last statement, in that the importance of achieving an 'end' (a cure or the patient's clinical progress) is intensified, while the paths to achieving that end are extended to approaches other than merely scientifically informed ones. As stated by one acupuncturist: 'we get the evidence through the outcome' (I5: TA).

Clinical pragmatism is still strongly related to other values such as clinical intuition, clinical empathy and charisma, which were seen by most participants as crucial variables in healing. The expression of these values seemed often an attempt to shift from an emphasis on standardised rules to an emphasis on 'charismatic knowledge', i.e. knowledge acquired through '... means that escape the rules and ... are attributed to virtualities' (Jamous and Peloille, 1970:115) of traditional acupuncturists and traditional homeopaths. CAM charismatic knowledge is well explored in the following quotation of a rank-and-file traditional acupuncturist with 25 years of practice:

There are some practitioners who have in fact a great feeling and others who have not. I mean, it's important to be technical enough and to know the rules but I think it's much more important being informed, sensitive ... well, this [being a practitioner] is in fact [a] very subjective [process]. It's very subjective. And I think we can get this skill through experience. (I5: TA)

Having a '*pragmatic ethos*' or a pragmatic disposition to healing was also justified by

all the traditional acupuncturists and traditional homeopaths through claims about the ‘unique experience’ and the ‘clinical idiosyncrasy’ of the healing process. In short, these practitioners claimed that every process of healing varies as the time and place of healing, the illness condition, and type of healer and patient varies. Healing is a process which entails transformations of the disease, the professional and the patient. For example, as one rank-and-file traditional acupuncturist explained:

If I decided to see a patient who I was about to see only tomorrow and if I decided to treat them [right now in the day time], then everything would be different from seeing them at night time and then perhaps the treatment would be different too. And [the consultation process] would even be more different if another colleague [and not me] happened to see them [the patient]. Because it isn’t just a matter of pressure points ... There can be a protocol based on a set of specific pressure points which can be prescribed by a practitioner today for a specific case at a specific moment but he himself some time later can change everything. This is even more likely to happen after one week with another different practitioner. Because there isn’t a protocol for each condition. ... *Diseases are not static.* (I3: TA, my emphasis)

The importance given by this interviewee to the indeterminacy of the healing process during acupuncture, which includes the practitioner’s idiosyncrasies or the changeable state of the disease or illness condition, is evident. The reference to such indeterminacy often appeared as an attempt to legitimise clinical pragmatism in CAM practice and to undervalue biomedical protocols and standardised guidelines for healing.

Clinical pragmatism also undermines scientific evidence by emphasising evidence based on history and on clinical experience. For example, traditional acupuncturists saw acupuncture’s approach to healing as being scientifically proven through history, rather than through the ‘conventional scientific methods’ set by biomedicine. As a traditional acupuncturist leader disclosed:

But [acupuncture] is already scientifically proven through a scientific approach but in a different way. So, I mean, there are billions of people that have been treated for certain pathologies [through acupuncture] and we [Western medicine] are still using a different type of [biomedical] approach. So, we want to play rugby with tennis rules but that’s something hard to do, you see. (I7: TA)

Although this participant’s rhetoric entails a viewing of acupuncture as clearly more effective than biomedicine in treating certain pathologies, this treatment largely remains under the remit of Western conventional healthcare using a biomedical model. He

explained this at a metaphorical level by conveying the idea that treating certain pathologies using 'biomedical rules' legitimated by randomised controlled trials, may not result in successful treatment. In other words, he asserted that camicising certain human problems may not be inappropriate.

In summary, it has been argued that holism, preventative care and health promotion, alternative healing and clinical pragmatism, as referred to by the respondents, are 'legitimacy values' of a specific kind: 'countervailing values'. The promotion of these values by traditional acupuncturists and traditional homeopaths was an attempt to counterbalance the imbalances of biomedical ideology and therefore mould the health marketplace to their own advantage. By adopting a professional rhetoric based on such conceptual resources (at the rank-and-file and institutional levels) and by attempting to apply them in their practice and workplace, traditional acupuncturists and traditional homeopaths in Portugal have attempted to promote CAM solutions and treatments to human problems. By shifting the emphasis on symptoms to an emphasis on patients and their environment, by highlighting preventative rather than curative medicine, by promoting CAM treatments in residual medical areas for which biomedicine has few solutions and by emphasising clinical pragmatism over evidence-based practice, traditional acupuncturists and traditional homeopaths have attempted to promote an alternative framework for the treatment of health problems. In a way, they have attempted to appropriate not only jurisdictional areas of medicine (in this section the usurpation of residual medical areas was a main example), but also other areas of life such as the promotion of health. The healthy person has thus become a main focus for the expansion of camisation.

Alongside the underscoring of countervailing values, traditional acupuncturists and traditional homeopaths also engaged in professionalisation strategies as a way to achieve occupational closure and legitimacy and therefore succeed in the camisation of health in Portugal. We will look at this idea next.

Professionalising

Professionalisation strategies are of an inclusionary form as they clearly relate to the attainment of occupational closure and legitimacy mainly through the achievement of credentialism or of a specific knowledge system. In the case of CAM, professionalisation strategies have been in line with global health policy trends which

have supported the rise of CAM practitioners' credentials and qualifications in order for them to ascend professionally. Increasing 'institutional' and 'occupational' credentialism (Freidson, 1986) illustrates the main professionalisation strategies used by traditional acupuncturists and traditional homeopaths in the research reported here. These strategies will now be considered in more detail.

Increasing Institutional and Occupational Credentialism

Institutional and occupational credentialism of CAM in Portugal has increased especially since the approval of the new Act 45/2003. For example, increasing the number of organisations which operate as legal entities to establish CAM credentialism, and increasing the number of CAM practitioners with a valid license to practice, are the main professionalisation strategies used by traditional acupuncturists and traditional homeopaths. This was illustrated by a traditional homeopathic leader and representative from the school *Advanced Studies in Naturology* (*Estudos Avançados de Naturologia* - EAN):

JA: What's the best way to know at the moment if a CAM practitioner is competent or not?

I: By asking where they were trained. Asking for their professional credentials, if they've got professional credentials ... first if they've got training, what's the length of it, what tutors they've got. And then also if they're registered in any Federation⁹ or *Câmara*¹⁰ which supervises, let's say, their professional activity. Because in order to start practising, they need to get training and get their license through an association, or federation, or syndicate, or any other corporate institution. (I14: TH)

This quotation is also representative of the growing desire of traditional homeopaths to acquire group cohesion by establishing self-governing bodies to regulate this therapy. The reference to the umbrella bodies the FENAMAN, which supports the legitimacy of CAM practitioners in the country by promoting scientific, juridical and technical information among the different associations, and the previously mentioned CNNET, a post-CAM Bill association, were good examples. The latter registers only 'trained naturologists', which are defined as applicants who entered a CAM course with at least a secondary school degree (grade 12, the equivalent to the British A-level qualifications), who completed their higher education in CAM as well as their

⁹ The participant is referring to the FENAMAN (Federação Nacional de Associações de Medicinas Alternativas Naturais – National Federation of Natural Alternative Medicine's Associations).

¹⁰ The participant is referring to the CNNET, already mentioned before.

specialisation in a CAM therapy in a school accredited by the 'Câmara', and who completed internships in clinics under the supervision of a registered specialist accredited by the 'Câmara' (CNNET, 2005). The CNNET was also associated with a now defunct undergraduate course in 'Non-Conventional Therapeutics' (*Curso Geral em Terapêuticas não Convencionais*) hosted by the ESTAL (*Escola Superior de Tecnologias e Artes de Lisboa*). This course used to focus on the six specific CAM therapies under statutory regulation – acupuncture, homeopathy, osteopathy, naturopathy, fitotherapy and chiropractic – and was one of the most recently established post-CAM Bill undergraduate programme in the country, which sought a harmonisation with the CAM Bill 45/2003:

[The ESTAL seeks to] determine competences in non-conventional therapeutics' and '... guarantees the professional accreditation to clinical practice of those [therapies] expressed in the [CAM] Bill 45/2003 – Homeopathy; Naturopathy/Phytotherapy; Osteopathy/Chiropractic; Acupuncture¹¹.

This undergraduate course, however, is not running anymore. According to an email from a homeopathic leader, there were:

Financial problems related to the institution in charge with the ESTAL, a complex process of selling the ESTAL to another institution, lack of support and interest from the part of the [ESTAL's] administration in running this [CAM] course, problems with staff payments, well, many other reasons that led to the end of the course (December, 2011).

As one can see, despite the desire to increase the credentialism of CAM, creating the conditions to raise CAM's standards in education has been a challenge for CAM practitioners. The divisions within the homeopathic community, the heterogeneous education across different schools and the sense of the State requiring CAM regulation were highlighted by the following homeopathic leader and a representative from the APH:

At the moment we have three different types of training schools. That's why we've got a bit confused. Because the Ministry should take a hand in this, you see. So, there's the Naturology course, which has four years of training in acupuncture, homeopathy and ... all with medical subjects in between. Then there's another one which gives two years of medical stuff and of basic naturology, plus two more specialised years [in one CAM therapy]. ... This one is

¹¹ In http://www.estal.pt/site/index.php?option=com_content&task=view&id=80&Itemid=137 (Accessed in October 2010)

the one in Lisbon, the ESTAL. And then there's another one ... which is older, the IMT ... The IMT offers a general homeopathic course in the same way as in the UK. It's the only one doing that. So, that's why we've got a bit confused. (I12: TH)

It was difficult for the researcher to obtain a precise number of homeopathic and acupuncture's associations and schools in the country due to their multiplicity. Some of the associations, however, should be referred to, not least because some of their members have been more directly involved in CAM regulation within the country. With regard to acupuncture, for instance, there is the *Associação Portuguesa de Acupunctura e Disciplinas Associadas* (APA-DA), whose chairman is a traditional acupuncturist and a well-known figure near the public, who has spread clinics of TCM in the country over the last decades. There is also the *Associação Profissional de Acupunctura e Medicina Tradicional Chinesa* (APAMTC), whose chairman was appointed as acupuncture's representative in the ad hoc Committee of the CAM Bill 45/2003 (see Chapter Five). The present research revealed a strong clash between these two associations and these two leaders, evidenced by their claims over the right to set up acupuncture's credentialism in the country. For example, although both associations have extended their training and education, their curriculums contrast with each other, particularly in terms of the total amount of hours a student must dedicate to TCM.

Besides these two associations, there are other important stakeholders such as the *Associação Portuguesa de Medicina Acupunctural* (APMA), which claims to be the oldest in the country (its foundation dates from 1982). There are also other graduate courses on offer in acupuncture, such as the ones from the *Instituto de Medicina Tradicional Chinesa* (IMTC), the *Instituto Português de Naturologia* (IPN) and *Estudos Avançados de Naturologia* (EAN), which provide more general courses on acupuncture and on 'naturology', an umbrella term which is predominantly used by traditional acupuncturists and traditional homeopaths as encompassing all CAM therapies.

So this shows the heterogeneity surrounding CAM's credentialism-making. The same heterogeneity could also be found at an institutional level in homeopathy. For example, the *Portuguese Association of Homeopathy* (APH) was founded in 1984 and has around 95 members at present. According to this association's webpage:

There are many more homeopaths, or at least naturopaths using homeopathy who are not members of our association since they have not recognised yet that it is of

interest to all of us joining all together in the same association, and there are still others whose requests haven't yet been accepted since the [APH's] administration has concluded that they do not have appropriate curriculum or knowledge to make part of our association.¹²

It can be concluded that the traditional acupuncturists and traditional homeopaths in this study were keenly aware about the need to increase credentialism if they want to achieve greater legitimacy with the public and within mainstream healthcare. This has led to the setting up of associations, schools and educational courses which have adopted and provided CAM definitions and approaches to human problems. So camisation has been present at the institutional level, as the setting up of many CAM organisations in the country with a CAM approach to health has demonstrated. Yet the clashes between some of these institutions and schools, the internal disagreements around CAM credentialism-making (an aspect developed in Chapter Nine) and the holding-up of CAM regulation by the State (as Chapter Five will show) have prevented acupuncture and homeopathy from moving faster in the professionalisation process. Consequently, CAM practitioners' professionalisation has been problematic and therefore has reduced the impact of camisation.

We should now move to a third type of strategies of inclusion used by traditional acupuncturists and traditional homeopaths in their attempt to acquire legitimacy by Portuguese mainstream healthcare. They are strategic alliances with biomedical science, and we should look at them next.

Forming Alliances with Biomedical Science

Strategic alliances as defined in this research are strategies used by CAM practitioners to foster their relationship with the biomedical science in order to increase their opportunities to camicise health and healthcare. On the surface, this seems a contradiction as allying with biomedical science means relying often on values contradictory to the 'legitimacy values' previously presented. This contradiction, however, could help show the strategic character of respondents' actions and discourses, an aspect that will be raised in the discussion of this chapter. Furthermore, the strategy of allying CAM with biomedical science is in line with the World Health Organisation's (WHO) guidelines on developing a sustainable use of CAM in Western countries. In the present research, allying with biomedical science appeared to be a main mechanism of

¹²In <http://aphomeopatia.weebly.com/histoacuteria.html> (Accessed on the 8th December 2009)

CAM practitioners to diffuse camisation and to achieve greater public legitimacy. The traditional acupuncturists and traditional homeopaths from this research disclosed two interesting strategies to acquire biomedical patronage: (1) infusing CAM with biomedical learning and discourse; and (2) promoting integrative medicine. This chapter shall now turn to look at each of these strategies in more depth.

Infusing CAM with Elements of Biomedical Science

One of the central points that arose from respondents' accounts was that although they claimed countervailing values in relation to modern medicine and attempted to demarcate their knowledge from biomedical knowledge, they also attempted to infuse acupuncture and homeopathy with biomedical learning and discourse. The high symbolic value of biomedical science and discourse that traditional acupuncturists and traditional homeopaths disclosed can be seen as a status improvement technique and therefore a way of acquiring greater legitimacy and occupational closure. The following quotation shows an insightful perspective from a traditional homeopathic leader involved with homeopathic credentialism in the country who appeared to tacitly use biomedical knowledge to legitimate the status of homeopathy:

Well, homeopathy doesn't need ... I'm gonna be honest with you... there are two stances ... And I support both of them. I should support the [biomedical] education and training stance, but [there is also the stance that argues that] homeopathy doesn't need medicine at all. Homeopathy is a totally different science. But it depends on the country and on the public, you see. So, in Portugal homeopathy always needs to have biomedical matters. (I12: TH)

This statement points to an institutional level strategy of survival for homeopathy within the healthcare market in Portugal. This leader emphasised the need for homeopathy to foster alliances with the biomedical world by infusing homeopathy with biomedical learning in order to ensure its survival in the healthcare market and to enhance its legitimacy. Other CAM representatives and leaders, although distinguishing CAM from biomedicine, acknowledged that appropriating the symbolic value of biomedical learning would help them to enhance their status in a country where the rhetoric of 'biomedical power' remains strong and dominant (Carapinheiro and Rodrigues, 1998; Carapinheiro, 2005). Therefore, not surprisingly, many acupuncture and homeopathic schools in the country have included the teaching of biomedical subjects such as anatomy, clinical pathology and physiology in their curriculums.

On the surface, this shows how acupuncture and homeopathy have changed their knowledge claims and have bowed to biomedical science. The infusion of biomedical science into CAM therefore has entailed the accommodation of scientific evidence. For most participants, the accommodation of scientific evidence was perceived as a way of coping with biomedical and statutory barriers and helping acupuncture and homeopathy detach themselves from charlatanism. The following statement shows the ironic view of a traditional homeopathic leader when referring to scientific evidence:

JA: Do you think that's important [to homeopathy] to get scientific evidence?

I: Yes, I think it is. To stop definitely with this situation [of CAM's marginalisation in the country]. We are charlatans ... (I13: TH)

Whilst being seen as a main ingredient of biomedical knowledge, scientific evidence did not seem to constitute a main criterion to practise homeopathy for this traditional homeopathic leader. Yet the respondents, mainly CAM leaders who have been involved in statutory regulation, were sympathetic to scientific evidence and were keenly aware of the importance of acting according to the scientific norms of biomedicine in order to achieve occupational closure and legitimacy themselves. This last quotation, for example, implies that there is a CAM strategic elite who claims that scientific evidence in homeopathy can prevent medical doctors from labelling traditional homeopaths as quacks.

Nevertheless, for the majority of respondent leaders the increase in the scientific evidence base of acupuncture and homeopathy was not seen to be without obstacles, such as the lack of governmental or commercial funding. The sympathy of these leaders for evidence-based research in homeopathy and acupuncture can be seen as going hand in hand with some of the major controversies that have surrounded CAM, namely how CAM research should be done and to what extent it should take into account scientific evidence.

At the discourse level, infusing CAM with biomedical language was also indicative of a strategic alliance between traditional acupuncturists and homeopaths and the medical profession. The discourse of the following traditional homeopath is clear in the use of biomedical language:

... Headaches for instance ... [imagine] if you get a migraine, not a regular

headache ... ok, I'll give you a non-steroid anti-inflammatory or rather I'll give you an anti-migraine pill with dubious effects. The anti-migraine stuff, more than 50% of that is considered ineffective. They nearly drop to the same level as placebo, which has only got a success rate of 30%. Water's memory [homeopathic theory] has got the same 30% as anti-migraine's medication. (I21: TH)

Like claims of evidence-based practice, adopting biomedical language, as illustrated by this quotation, was a strategy frequently employed by respondents. Moreover, it appears that by externalising a biomedical discourse, traditional homeopaths and traditional acupuncturists attempted to improve their status and convey the idea that they are 'complying with the rules' of the biomedical game. Nevertheless, this strategic allegiance is a double-edged sword. In the case of CAM's relationship with biomedicine, it will be interesting to see the extent to which homeopathy can maintain its strategy of infusing itself with aspects of biomedical science if accepted by mainstream healthcare and regulated by the State. As Abbott (1988) pointed out, legitimacy values change and take new forms over the history of professions.

In summary, infusing acupuncture and homeopathy with biomedical ideas and discourse has been an important mechanism of traditional acupuncturists and traditional homeopaths, which has enabled them to ally themselves with the medical profession and therefore benefit from the symbolic value attached to that learning and discourse. The convergence with biomedical science will provide them with higher levels of public trust and therefore will offer them opportunities to go further in their legitimisation process. In other words, it will help create better conditions for camicise health and healthcare.

We now turn to another kind of strategic alliance of CAM practitioners with biomedical science which is the promotion of integrative medicine.

Promoting Integrative Medicine

According to the WHO (2002), integrative medicine practised in integrative clinical settings such as private clinics or hospitals has recently emerged in Western countries. As Hollenberg (2006:731) put it, 'the development of 'integrative healthcare' settings ... is a relatively recent phenomenon among biomedical and CAM professions'. The sociological studies of Shuval et al. (2002), Mizrachi et al. (2005) and Mizrachi and Shuval (2005) examining the recent collaborative patterns between orthodox medical

doctors and CAM practitioners in hospital settings in Israel provide clear evidence of this. The emergence of integrative medicine represents a shift away 'from separating therapeutic modalities into categories such as 'biomedical' or 'alternative', towards a focus on merging diverse modalities into a 'new' integrative health system' (Hollenberg, 2006:732). This shift towards integrative healthcare can be seen as a recent strategy of CAM practitioners to be included into the mainstream healthcare system. By interacting with medical doctors and by sharing work settings, for instance, CAM practitioners have attempted to increase levels of public trust and survive in the marketplace.

According to Wiese et al. (2010), integrative medicine in its ideal form is concerned with collaboration and mutual respect between different medical systems. Furthermore, integrative healthcare provides 'multidisciplinary and interprofessional collaboration, offering a full range of mainstream and complementary medicine health services based on the needs of the patient' (Wiese et al., 2010:329). This point of view mirrors the ideal view of 'integrative medicine' among both traditional acupuncturists and traditional homeopaths. This aspect is clearly expressed in the following statement from a traditional acupuncturist leader:

So ... And we also seek [the medical doctors]. Because they are complementary and I should repeat again what I'd said in the beginning ... So, there is only one medicine and then there are different paths, different approaches. And all of them are valid. All are valid. I mean, none of them is better than the other in my opinion. So, all of them are complementary. The point is rather that we should be aware of this trans-disciplinarity. And if we are not [aware], then there is no medicine. (I6: TA)

For the most part, traditional acupuncturists and traditional homeopaths were keen on working in partnership with medical doctors and on establishing collaborative relationships with them. Several respondents provided examples of this:

I: I think that ... what I was talking about ... [medical doctors] should be better informed about what we exactly do if we want to interact with them. Otherwise, it'll be difficult to interact.

JA: What do you think medical doctors would win or lose with that interaction?

I: ... If a doctor runs out of options ... I cannot understand why they would have something to lose in saying 'look, I cannot really help you but someone can' ... and refer the patient to someone who can. (I2: TA)

Here we can see this CAM practitioner's claim that integrative medicine is predicated on a sense of harmony between biomedical and CAM practice. In this case, where CAM would be a second option and provide an alternative role in the healthcare system. According to this participant, traditional acupuncturists could 'help' medical doctors solve patients' problems. This idea of being an 'alternative' to biomedicine, although often rejected by many traditional acupuncturists, was evident in many contexts. This seemed to be a tactical negotiation however: by admitting to being a second choice, acupuncturists were able to maintain their own 'legitimacy values' (Abbott, 1988), and prevent subordinating their knowledge and practice to the medical profession.

Nurturing a (referral) relationship with medical doctors and with other biomedical professionals was a strategy of allegiance with the medical profession often referred by many traditional acupuncturists and traditional homeopaths in this research. As the following traditional acupuncturist leader disclosed:

I have found more and more medical doctors open to ... I have many patients whose doctors have referred them to me, I have many doctors as patients, I have many doctors' relatives as patients ... Let's say that [acupuncture's results] might have to do with individual characteristics, let's say, with the results achieved and the individual work of each practitioner, right? (I7: TA)

What can be concluded from this last quotation is that the negotiation of the relationship between traditional acupuncturists and medical doctors is carried out for the most part at a micro level; that is, on a case-by-case basis, being dependent on contextual factors such as the 'likeability' and 'affinity' (Lerner, 2008) of both professionals. Furthermore, at an institutional level, improving the relationship between CAM and biomedicine remains illusory, suggesting that this relationship has not been replicated at all levels, with considerable differences between the rank-and-file and the elite. The following statement from a traditional homeopathic leader and a representative from the APH clearly shows evidence of the number of current imbalances between the interactional and the institutional level relationship between CAM practitioners and the medical profession:

JA: What's the difference between traditional homeopaths and medical homeopaths?

I: It's a matter of elitism, nothing more. I know great medical homeopaths. Doctors, really. Here in Portugal. I know an Argentinean, a Mexican, a

Portuguese, but ... we don't have ... let me say ... we don't get on badly with the medical homeopaths. That's not the point. The point is the Medical Council. And not the medical homeopaths. It's the Medical Council who doesn't want to have anything to do with us, so ... it's just a matter of competition. Nothing more. (I12: TH)

As this statement shows, professional interaction between traditional homeopaths and medical doctors, especially those medical doctors committed to homeopathy, were well received by participants. Nevertheless, despite efforts of CAM practitioners to foster integrative medicine, the latter has remained 'virtual' or idealistic in Portuguese society. Integrative medicine settings and collaborative work between biomedical doctors and CAM practitioners in publically funded healthcare settings have been poorly articulated. Infrequently, a few respondents also disclosed stories around their partnership with some medical doctors through sharing the same clinical setting. Many of CAM practitioners' attempts to practise integrative medicine in integrative healthcare settings such as clinics were damaged by the quarrels among the professionals, who ended up disbanding the collaboration, as the following quotation from a traditional acupuncturist leader exemplifies:

... I can tell you, for example, in one clinic where I was, I went there twice or something. One clinic in [name of the town], I was invited to by the medical director. I went there to work. The clinic was specifically for physiotherapy. So, I thought I could do many things there. I only had three patients. Why? Because one of the ladies there, the physiotherapist, felt extremely intimidated by my presence [in the clinic]. So, there weren't patients asking for anything. Which I cannot believe. So, these conflicts exist ... (I6: TA).

This last statement suggests that established health professionals show relatively little interest in fostering working relationships with individual CAM practitioners in Portugal. Despite the WHO's (2002) recommendations about collaboration between biomedicine and CAM therapies, integrative medicine in Portugal, like in most of other Western countries (Wiese et al., 2010), has almost remained virtual. Evidence reported in Chapter Five and Chapter Six will also show that incorporation rather than integration has been the predominant form of CAM inclusion in Portuguese mainstream healthcare. This goes in line with previous studies which have shown that the promotion of integrative medicine has been limited in other countries. For instance, in their review of the literature on the relationship between CAM and mainstream healthcare practitioners, Wiese et al. (2010) recognised that those CAM practitioners who have embarked on collaborative work with biomedical doctors in integrative healthcare

settings continue to be marginalised, although they acknowledged that there has been an overall increase in the inclusion of CAM therapies in mainstream healthcare.

In summary, traditional acupuncturists and traditional homeopaths in this study have engaged in different strategies of inclusion into mainstream healthcare in Portugal. Expressing countervailing values has been a main strategy of closure. Professionalising and forming allegiances with the medical profession in turn have been identified in this research as two other main strategies of inclusion used by CAM practitioners which, if successfully achieved, would put them in a better position to camicise healthcare. The term ‘camisation’ has been introduced to show the desired result of these strategies: the promotion of CAM treatments and solutions to everyday human problems. Furthermore, these strategies seem to be in line with patients’ interests and with recent global trends in health-policy, particularly mirroring a general turn towards a pluralistic approach to healing in Western societies.

Alongside strategies of inclusion into mainstream healthcare, demarcationary strategies of CAM practitioners in relation to biomedicine and charlatanism in order to win legitimacy and therefore promote their interests within mainstream healthcare were also identified by this research. This chapter will look now at these strategies in more detail.

Boundary Demarcation

As Witz (1992:46) points out, ‘demarcationary strategies are concerned with the creation and control of boundaries between occupations’ in the division of labour. They can be applied by subordinate occupational groups as a form of resistance towards dominant groups, but they can also be applied as a way to consolidate the position of subordinate occupational groups within the division of labour (Witz, 1992). Most of traditional acupuncturists and traditional homeopaths referred to demarcationary strategies in this study. This chapter shall turn now to consider them in more detail.

Demarcating from Biomedical Knowledge

Traditional homeopaths and traditional acupuncturists often claimed to distinguished themselves from biomedical doctors and their underlying biomedical knowledge. This aspect became particularly evident in the context of critiques of those medical doctors who have embraced acupuncture and homeopathy, i.e. medical acupuncturists and

medical homeopaths. When asked about medical doctors' using homeopathy in Portugal, a traditional homeopathic leader and a representative of the FENAMAN made the following knowledge claim:

There is a gap in [medical] homeopathy, because doctors turn to homeopathy, and even if they happen to be very good homeopaths, they've got a *stigma* called medicine. So, they learned a healing art totally different from [homeopathy]. If they happen to have the knowledge and an idea about the best remedy that they should apply ... well, that's fine. But that isn't homeopathy. Homeopathy doesn't work with a biomedical framework ... [scientific knowledge] cannot be applied to test homeopathy. Because the patient is approached in a very different way. They [doctors] work with a 'symptomatic homeopathy' and not with the simile's principle. (I19: TH)

By claiming that 'medical homeopaths' (that is, biomedical doctors who practise homeopathy in Portugal) often follow a 'symptomatic approach' to this therapy, this statement reveals a critique of the biomedical use of homeopathy, and thus an attempt by the respondent to demarcate their occupation. In other words, the biomedical use of homeopathy is criticised for being a reductionist measure as it focuses on treating symptoms through clinical protocols, thus disempowering the 'idiosyncratic healing' principle of this therapy. This participant also illustrates a demarcationary strategy towards biomedicine by emphasising the epistemological conflict between biomedical and homeopathic knowledge. As the above quotation suggests, although medical homeopaths may have some 'homeopathic knowledge', they remain too reductionist in their approach to healing, as they tend to ignore illness factors which go beyond biological or physiological ones.

In a similar fashion, traditional acupuncturists often referred to a 'symptomatic acupuncture':

Look, a traditional acupuncturist ... let's say it the other way round ... a *symptomatic acupuncturist* has got training [in acupuncture] which can even be long but they've got used to ... treat with protocols. That is, if somebody gets an allergy, such as renitis, a discal hernia, [the symptomatic acupuncturist] has a prescription. He's gonna be needling this, this, and that. This is what the symptomatic acupuncturist does.' (I5: TA, my emphasis)

For this rank-and-file traditional acupuncturist, 'symptomatic acupuncturists' included 'medical acupuncturists' (medical doctors who practise acupuncture alongside their medical practice), but also traditional acupuncturists who were biomedicalised, i.e.

‘converted’ to the biomedical discourse by ‘listening to symptoms and generating a treatment protocol’ (I5: Traditional acupuncturist). The demarcation from biomedical knowledge is reinforced by the shared feeling among the respondents of having their field hijacked by medical doctors and other conventional healthcare practitioners. As another traditional acupuncturist leader clearly put it:

Then medical doctors show up. Nurses show up. Everyone shows up ... massage therapists, whatever, all of them with needles in their hands and needling. Of course acupuncturists don’t like this. What’s going on here? So, we need to study over five years, we need to get training, we study for ... five years and five thousand hours and so on ... and then someone just turns up and says that they are acupuncturists and also needle like me? What’s going on here? (I6: TA)

This quotation illustrates the general feeling among the participants that the increasing use of CAM by medical doctors and other allied healthcare professionals such as massage therapists, nurses, psychologists and physiotherapists, represents a usurpation of their expertise. Once again, the biomedical use of CAM and the qualifications of biomedical practitioners emerge as deficient and limiting, in opposition to the qualifications held by homeopaths and acupuncturists who use a more traditional approach to handling these therapies.

This attempt to demarcate CAM practitioners from medical doctors and their underlying biomedical knowledge was also visible at an institutional level. Before the new CAM bill had been approved, Jerónimo Sardinha, the chairman of a now defunct *Commission for the Coordination of the Regulation of Naturology* (Comissão Coordenadora para a Regulamentação da Naturologia – CCRN), had commented in a TSF¹³ radio interview about the governmental consultations with the Medical Council about the importance of CAM:

How come the [Medical] Council is going to get involved in a reality [CAM regulation] about which they don’t know anything and have always defamed? (TSF Online, 8/06/00)

This ironic quotation discloses the uncomfortable relationship between CAM and the medical profession at an institutional level in Portugal. It addresses in a very subtle way the issue of CAM’s ‘specialised knowledge’ which should not be accessible to anyone other than CAM practitioners, and also points to the lack of credentials of medical

¹³ Telefonia sem Fios (Wireless Telegraph)

doctors to practise CAM. This last claim in particular reminds us of the claims against charlatanism. When asked about the extent to which medical doctors have acquired appropriate homeopathic knowledge and have embraced homeopathic principles, one traditional homeopathic leader also disclosed the following, in response to a question from the researcher:

JA: But are doctors aware of homeopathic knowledge and principles?

I: I don't think so. I don't think so because it's not during the weekends or whatever that all these things are learned. The homeopathic *Materia Medica*¹⁴ is too complicated. It takes years. I've been on this for 40 years and I still don't know it very well. (I19: TH, my emphasis)

This leader attempted to use professional experience and lengthy, specialised training in homeopathy to justify occupational closure or control over a jurisdiction. CAM knowledge is seen as 'expert knowledge' that, as Cant and Sharma (1996c:6) have reiterated, can only be mediated by 'a small number of people with the appropriate qualifications and abilities'. Alongside others, this participant also emphasised the economic and market orientation of biomedical interest in homeopathy and gave examples of professionals who are reflective of biomedical interests and have been poaching CAM for economic reasons. As one traditional homeopathic leader commented:

... Another annoying thing is seeing the psychologists always trying to get into our area. A psychologist doesn't have training in homeopathy ... They take basic homeopathic courses and then they ... then ... I've got a friend who came to see me with a serious problem and someone prescribed her fifteen remedies. And all antagonistic. ... Psychologists! Because they don't have clients, they try to get ours. (I12: TH)

Additionally, the changing status of acupuncture over time in the country was often sarcastically related to the presence of a strong biomedical power. As an acupuncturist leader put it:

... Thirty or thirty five years ago ... [Traditional] Chinese Medicine was one thing ... it was a nonsense thing for most of the people ... then later on it changed to something like ... something more or less related to witchcraft, let's say ... I'm exaggerating a bit. After a while it changed to placebo. Then [it] started being

¹⁴ The homeopathic *materia medica* is a remedy reference guide and gives information about homeopathic remedies. It lists all the homeopathic remedies and their symptoms. It should be used simultaneously with the homeopathic repertory.

seen as something of interest and in the last five, six years only the doctors can practise it. So, it was a quick evolution. (I7: TA)

In summary, it can be stated that CAM practitioners have attempted to demarcate themselves from biomedical science and this aspect has been made evident through the respondents' accounts about the differences between a traditional acupuncturist/homeopath and a medical acupuncturist/homeopath. By demarcating themselves from biomedical science CAM practitioners seek to protect CAM's 'specialised' knowledge by showing that the medical profession has inappropriate credentials to practice CAM. It implies in a way the employment of exclusionary strategies in order to consolidate CAM's own position within healthcare. Alongside attempts to demarcate themselves from biomedicine, CAM practitioners also showed attempts at boundary demarcation in relation to charlatanism. We will consider this intra-demarcationary strategy next.

Demarcation from Charlatanism

Demarcation from charlatanism was often associated with intra-demarcationary strategies and ways of activating occupational closure and acquiring legitimacy. The following statement from a traditional acupuncturist leader and representative from the APAMTC illustrates this type of demarcation very clearly:

It takes time to complete training on CAM. Of course there are abusers. And because there are abusers ... some people take advantage of that. ... I mean, they [some CAM practitioners] have got basic training. Then, of course ... the practitioners themselves, they aren't really practitioners, they're for instance bank employees who during the night do a bit of needling or prescribe a few things while they are off and so ... So, [acupuncture] is not taken seriously [by those who practise it], that's it. And then the Medical Council takes advantage of that. The [Medical] Council defames everything [about CAM] when those behaviours come out. So, it's really silly if I'm a bank employee, I'm over the counter all day long and then when the night comes, when I'm off, I turn to a room and say I'm an acupuncturist. So, what does that mean? Am I an acupuncturist, a bank employee or what? (I6: TA)

One of the central issues emerging from this quotation is the lack of internal or 'group cohesion' (Kelner et al., 2006; Welsh et al., 2004) that persists amongst traditional acupuncturists and also amongst traditional homeopaths in Portugal. As mentioned earlier, there was strong evidence of a clash among acupuncture and homeopathic schools and associations in the country. This same participant, when questioned about

traditional acupuncturists' credentialism and professionalism, pointed to the institutional tensions inside acupuncture:

I: Those with professionalism are [capable of diagnosing].

JA: And who are those with professionalism?

I: Those who at the moment ... those who went to the *Graduate School of Traditional Chinese Medicine* [*Escola Superior de Medicina Tradicional Chinesa* - ESMTC]. Anyone else. Hmm ... and then there are foreign practitioners and so. There are some people with credentials [to practise acupuncture]. I'm a friend of a few *masters* [of acupuncture] ... and then there are people who have got training in England, for example. (I6: TA)

It is apparent from the above statement that the right to set up credentialism over Traditional Chinese Medicine (TCM) – the field wherein acupuncture is usually positioned – is claimed by this traditional acupuncturist. The ESMTC is one of the strongest graduate schools in TCM in the country, and is closely related to the abovementioned APAMTC. While there are a variety of schools and associations of acupuncture in the country, the ESMTC appears to clash with another graduate school in the CAM educational market, the *Chinese Medicine's High School*, closely related to the *Portuguese Association of Acupuncture and Related Disciplines* (APA-DA), which also lays claim to the right to credentialise TCM. Foreign 'masters', who were usually described as charismatic teachers possessing informal training and a 'charismatic transmission of knowledge' (Cant, 1996) in TCM, and Portuguese lay practitioners who graduated in TCM in countries such as the United Kingdom (a country chosen by many of those who seek training in acupuncture and homeopathy), were also considered legitimate.

Also, several traditional acupuncturists and traditional homeopaths claimed that the unfinished statutory regulation of CAM in the country had not helped in preventing the charge of charlatanism and had contributed to occupational anarchism. As a rank-and-file traditional acupuncturist declared:

Because acupuncture hasn't been regulated yet, this has led everyone to practise it. There are no rules in relation to this profession, and this helps spread the number of unqualified professionals. ... Because there are schools that offer acupuncture training over only three months and there are acupuncturists like me doing clinical acupuncture and there are persons with three month training on it and at the end of the day they end up practising exactly like me, you see. And they

aren't prepared to do that. (I1: TA)

This respondent identified statutory regulation as an efficient way of demarcating CAM from charlatanism, providing that the Portuguese government did not delay CAM regulation in the country.

CAM practitioners' demarcation from charlatanism is also visible at an institutional level. In a February 2008 report from the FENAMAN, the chairman João Ribeiro Nunes commented on the unfinished regulatory process of CAM:

The Federation [FENAMAN] has many times posted letters to the Ministry of Health, has made phone calls, has sent faxes and has been welcomed, last time on the 12 November [2007] by the Minister's assessor, where we could explain our concerns about the anarchy in the area lately, with unqualified people trying to get in [CAM] and with the spread of pseudo-techniques which are claimed to represent Naturopathy and non-conventional treatments, endangering people's health and also questioning the good name of CAM and the honest work of colleagues from [CAM] associations and federations over the last 30 years. (February, 2008)

This statement expresses claims about intra-occupational homogeneity and also carries the suggestion that CAM practitioners have considerable institutional power and have an active role in its own regulation. The argument that the law is required to protect the 'honesty of CAM practice' and the persistent efforts made by CAM practitioners to contact the Ministry of Health have been mechanisms to activate intra-demarcationary strategies of closure.

In summary, boundary demarcation from 'dangerous practitioners' (Wahlberg, 2007: 2315), i.e. from those '... who [are] deemed to be practicing medicine (whether complementary, alternative or modern) irresponsibly, incompetently or unscrupulously to the detriment of the public', has been a significant strategy of closure. By demarcating CAM from biomedicine rather than aiming to be included or accepted by the medical profession, CAM practitioners have attempted to protect their knowledge and consolidate their own position within health and healthcare in Portugal. Furthermore, by drawing internal boundaries, CAM practitioners seem to employ strategies of exclusion themselves on the basis of credentialism. So the creation of demarcationary boundaries has been a main mechanism to improve the conditions under which camisation can be achieved. We now turn to a discussion of the main findings.

4.3. Discussion

This chapter has addressed the following research question: (1) what main strategies have CAM practitioners used to promote alternative conceptualisations of healing within mainstream healthcare in Portugal?

A new concept has been introduced to frame this analysis: camisation, or the process by which human problems become defined and treated in CAM terms and within a CAM framework. The main strategies used by CAM practitioners at a micro and meso level in order to spread camisation in Portugal in the 2000s have been analysed.

In this chapter acupuncture and homeopathy have been presented as the two main cases for analysis. Traditional acupuncturists and traditional homeopaths have been presented as (re)active rather than passive actors in their relationship with the medical orthodoxy and its underlying biomedical science. From a social closure perspective, they have clearly activated strategies of closure to promote their interests in the field of healthcare (Kelner et al, 2004). As in other Western countries, strategies of inclusion have been the main acupuncture and homeopathic strategies of closure. These have involved attributing blame to biomedical ideology and seeking to counterbalance biomedical imbalances and excesses over time. For example, it appears that acupuncture and homeopathy have taken advantage of purported biomedical excesses and imbalances by seeking to gain control over work domains such as holistic care, preventative care and health awareness. In this chapter, these themes were presented as ‘legitimacy values’ of a countervailing nature, i.e. values promoted by CAM practitioners which tend to criticise, oppose, complement or be alternative to biomedical values. By expressing countervailing values, traditional acupuncturists and traditional homeopaths have attempted to convince society that they are useful and necessary. The expression of countervailing values can thus be seen as a main strategy of CAM practitioners to acquire legitimacy and control over jurisdictional spaces left open by biomedicine.

A main theme emerging from the analysis of countervailing values was the proposed shift towards a patient-based approach to health. The emphasis given to the patient was present in most of the countervailing values. In the case of holism, the shift from an emphasis on the symptom to an emphasis on the patient was clear at both the institutional and the agency level. In the case of preventative care and health awareness, a shift from curative to preventative care which implies the patient’s responsibility

towards their health was highlighted, at least at a conceptual level. Alternative care, in turn, was often legitimised through an emphasis on its benefits to the patient. Lastly, in the case of clinical pragmatism there was an emphasis on the idiosyncrasies of the patient in order to legitimise an approach to health less informed by scientific evidence. To summarise, the emphasis on the patient appeared to be an important resource for acupuncture and homeopathy to camicise Portuguese healthcare.

At an institutional level, the power of CAM practitioners in Portugal has greatly increased. The data obtained from leading actors within acupuncture and homeopathy, when triangulated with documentary analysis, have shown that these two therapies have engaged with an array of professionalisation strategies to achieve occupational closure. Nevertheless, there is a significant lack of ‘group cohesion’ (Kelner et al., 2006) and numerous internal factions still exist among schools and associations, as will be explored in more detail in Chapter Nine. The tension between the grassroots and the elite levels in CAM’s interaction with medical orthodoxy was also evident. ‘Medical elitism’ - the belief of the medical profession in its perceived superiority within healthcare - was seen by traditional acupuncturists and traditional homeopaths as being more apparent at the institutional rather than the rank-and-file level.

Besides the expression of countervailing values and professionalisation, forming alliances with the medical profession seemed to have been another significant strategy of closure. At the discourse level and also at the educational level, infusing CAM with biomedical science was a key strategy employed by CAM practitioners. Yet at an interactional level, traditional acupuncturists and traditional homeopaths’ accounts of their relationship with biomedical practitioners and their involvement in integrative care settings demonstrated how integrative care is perceived as idealistic. Together, these actions represent an attempt by CAM practitioners to ally CAM with biomedical science in order to achieve some of the benefits obtained by the medical profession and biomedical science, such as the symbolic status. These actions are thus an important part of traditional acupuncturists and traditional homeopaths’ attempts to achieve legitimacy and therefore to camicise healthcare.

The contradictory nature of the strategies and the tension between some of the actions used by traditional acupuncturists and traditional homeopaths to activate occupational closure is easily perceived by comparing the data presented in this chapter. For

example, on the one hand, in the context of defending their own professional knowledge, claims by traditional acupuncturists and traditional homeopaths to demarcate themselves from biomedical science and biomedical professionals were made. On the other hand, in the context of the inclusion of CAM into mainstream healthcare, strategic allegiances with biomedical science and sometimes directly with biomedical doctors were also unveiled. Furthermore, while in certain situations claims for scientific evidence in support of CAM were emphasised, in other contexts the ‘*ethos*’ or disposition towards pragmatic healing (Quah, 2003), the ‘charismatic transmission of knowledge’ (Cant, 1996) and the authority of experience and the past were highlighted. The claims of traditional acupuncturists and traditional homeopaths as complementary practitioners who make use of gentle therapies contradicted their claims as practitioners who can present alternatives to certain biomedical procedures. Finally, if in some research contexts a preventative focus was attributed to CAM, in others the characteristics of CAM’s curative powers were highlighted. These contradictions are reflective of a countervailing process by traditional acupuncturists and traditional homeopaths within Portuguese mainstream healthcare to acquire occupational closure and legitimacy and, therefore, of a postmodern turn in healthcare, with the emphasis on pluralism rather than on monism.

The term ‘camisation’ therefore has been analysed as a process deriving from a set of strategies that are acted on by CAM practitioners in order to acquire occupational closure and legitimacy in Portuguese mainstream healthcare. Furthermore, it has been expressed as an ongoing process which draws parallels with the process of ‘medicalisation’ (Conrad, 2007). In a similar way that ‘medicalisation’ ‘describes a process by which nonmedical problems become defined and treated as medical problems’ (Conrad, 2007:4), camisation refers to the emergence of CAM definitions for previously nonmedical or medical problems.

The relationship between camisation and medicalisation is of value. Camisation can have different degrees in its relationship with medicalisation. For instance, it was revealed in this chapter that camisation can, at times, overlap with medicalisation in the sense that biomedical conditions can also be CAM conditions. Chronic pain, for instance, although increasingly camicised, has been managed by chemical pills, by CAM treatments, or by a combination of the two. At the same time, it could be said that camisation has been a main driver of demedicalisation, as some medical problems have

been increasingly transformed into problems to be treated by CAM, at least at the conceptual and also the societal level. Chronic pain is again a good example. It is outside the scope of this chapter to develop a conceptual model of camisation with its differential stages. Here the focus has been more on the main strategies towards camisation than on the process of camisation itself, although these two aspects often entwined.

This chapter has presented specific strategies of inclusion and demarcation of CAM practitioners to achieve occupational closure within mainstream healthcare in Portugal at the beginning of the 21st century. One could ask, however, why CAM practitioners have opted for these and not other strategies. For example, why have CAM practitioners opted for strategies with the main aim of camicising health and healthcare, rather than bending or adapting itself to the biomedical science? An immediate reason for this is that CAM practitioners do not want a subordinate relationship with the medical profession. However, professional desires do not exist in a vacuum. For instance, CAM practitioners' strategies presented here appeared to synchronise with recent patients' interests and with new global trends in health policy: the move towards pluralism in healing. In other words, it appears that social and political soil has been suitable to nurture CAM practitioners' strategies. Without this suitable soil, CAM practitioners might have had to opt for traditional strategies of subordination or adaptation to biomedical science previously used by other occupational groups and which would not offer CAM professionals the same conditions to thrive and to fulfil their own interests in spreading and acquiring control over camisation. For this reason, the concept of camisation may be particularly applicable to the Portuguese healthcare in the early 2000s and may not apply in other contexts, at other times and with other CAM therapies.

The extent to which the strategies of closure enacted by CAM practitioners in Portugal have been successful largely depends on the political context that has nurtured these strategies. For instance, although promotion of forms of camisation date back to earlier periods in history (particularly in the case of some therapies) camisation has been revived since the late 20th century in Portuguese society, especially as political interest in CAM increased and thus resulted in the statutory regulation of six CAM therapies through the approval of the Act 45/2003. In the next chapter we will address the impact that the recent political context has had on the success of CAM strategies in the country.

CHAPTER FIVE

THE COUNTERVAILING POWERS OF CAM, THE MEDICAL PROFESSION AND THE STATE

5.1. Introduction

In Chapter Four CAM practitioners were presented as agents of change in Portugal's healthcare system. A camisation process, by which CAM practitioners have promoted CAM solutions to everyday human problems, was put forward and the main strategies of these actors to camicise healthcare in Portugal were analysed. These strategies, however, have not taken place in a vacuum, but rather within a specific political context. Previous research (Kelner et al., 2006; Saks, 2003) has shown that the support of the Western modern State has been a crucial resource for the success of CAM strategies and therefore camisation. In the present Chapter the analysis of the spread of camisation in terms of the alignment of the State with CAM interests will be considered. The specific political context within which camisation has operated and the role of the Portuguese State in facilitating or constraining its success will be analysed. The analysis will go back to the late 1990s, when the Portuguese government sowed the seeds for CAM regulation.

It has been argued that what is distinctive about CAM revival from the late 1960s onwards is the unprecedented amount of political attention that it has received (Saks, 2003). On the one hand, supranational organisations such as the *World Health Organisation* (WHO) and the *Council of Europe* have fostered guidelines on CAM policy and have encouraged national states of many Western countries to establish an adequate legal framework for CAM and to integrate CAM into the national healthcare system. On the other hand, the trend already mentioned in Chapter Two of many Western governments targeting their health policies on a public health agenda, by paying attention not only to ill health and disease but also to health and to providing the conditions to maintain healthy populations (Hunter, 2003), has encouraged various Western States to stop dismissing CAM. To summarise, there has been increasing State and supra-State interest in CAM, as the latter has been seen as beneficial for reshaping health policy and for providing greater efficacy in the treatment of certain health conditions. The Canadian (Kelner et al., 2006), the Australian (Baer, 2006; Willis, 1983), the North American (Baer et al., 1998b) and the British states (Saks, 2002) have been some of the most sympathetic to the aspirations of CAM practitioners. It is

therefore of interest to know the extent to which the Portuguese State has been sympathetic to the aspirations of CAM practitioners to camicise healthcare.

In order to analyse the current political context of camisation in Portugal, an approach to the professions which sees the latter as operating within a field force of countervailing powers will be adopted (Light, 2000). As showed in Chapter Two, the concept of 'countervailing powers' (Light, 2000) refers to the interaction of 'powerful actors in a field where they are inherently interdependent yet distinct' (Light, 2000:203). Each of these interdependent actors or countervailing powers is competing within the health arena and each fighting for higher status, power, market opportunities and money (Light, 2010). There are also strategic allegiances between certain partners. With regards to the State, as Light (2010:271) put it, it is '... a constellation in itself of countervailing power groups or divisions with different functions and priorities'. Certain political parties, for example, can forge allegiances with emerging occupational groups such as CAM in order to challenge the political order and the prevailing healthcare system. Similarly, the profit-oriented philosophy of health corporations such as the pharmaceutical industry can lead to organisations expanding their influence on the market by allying with and creating market niches for CAM, for instance.

The study of Kelner et al. (2006) about chiropractors in Canada has constituted an original contribution to the countervailing powers' model in that it presents CAM practitioners as a recent countervailing power within the healthcare arena and gives an overview of how CAM has interacted with its interdependent partners, the medical profession and the State. According to Kelner et al. (2006) and also Coburn and Biggs (1986), allying with the State and attaining statutory regulation has been a main strategy of chiropractors in Canada to succeed in their strategies. The same strategy has been used in other Anglophone countries such as Australia (Baer, 2006; Willis, 1983) by acupuncturists, chiropractors and osteopaths, the USA (Baer et al., 1998b) by acupuncture, and the UK, with the passing of the osteopaths and chiropractors Act in 1993 and 1994 respectively. So in the abovementioned countries, CAM practitioners have acted as a countervailing power in that it has been able to generate State interest in CAM and therefore to challenge the balance of power within the healthcare market. In this Chapter, this countervailing powers model will be employed to frame the contemporary relationship between CAM, the State and the medical profession in the Portuguese society.

Although State interest in CAM has increased in Western countries, CAM legislation has not been a neutral process and has varied greatly from one country to another. It has been influenced by country-specific and socio-political dynamics and so it has been a complex process influenced by strategic power relations between interest groups. This is to say that different countries have different field forces of countervailing powers (Light, 2005). The idea of the State as a broker (Dunleavy and O'Leary, 1987) explored earlier in Chapter Two goes hand in hand with the concept of 'countervailing powers'. This State approach looks at policy-making as a process colonised by interest groups such as CAM practitioners and the medical profession. At the same time, however, it attributes great autonomy and partisan interests to the State. The idea of the modern State as an intrusive institution in the lives of citizens through an 'extensive network of services' such as councils, ministries, departments, committees and other authorities, powerfully evidences the interest of the State in exercising power in civil society (Green and Whiting, 1996:1). All these networks of services represent countervailing powers in that they play a central role in institutionalising professions. So the perspective of the State as a broker, in the same way as the concept of 'countervailing powers', sees policy-making as the result of readjustments between the interests of the State itself in maintaining its own legitimacy and the pressure and constraints of pressure groups in society such as CAM practitioners and the medical profession.

In Portugal little consideration has been given by social researchers to the current interaction of CAM practitioners with the countervailing powers of the State and its network of services, the political parties and the medical profession; the regulatory process of CAM in this country appears to be too interesting to be ignored. This is for two main reasons: first, State regulation has clearly been one of the main resources used by CAM practitioners to succeed in their strategies to camicise health, in spite of having received a tardy reception by the Portuguese government; second, the interaction between the interest groups of the State, the medical profession and CAM practitioners since 2003 has resulted in a delay in CAM legislation in the country, which means that Portugal is lagging behind other Western countries, such as Canada, the USA, the UK or Australia. Having said this, the present Chapter addresses the following research questions: (1) To what extent has the Portuguese political context sustained the success of CAM practitioners' strategies? (2) To what extent have CAM practitioners and the medical profession influenced State policy in Portugal? Attention will be focused on data generated from documentary search from the late 1990s until now. Newspaper

articles, specialised magazines, association's websites, leaflets and newsletters, legislative documents, radio interviews and emails were the main source of documentary data.

In this Chapter the scene of the regulatory framework of CAM in Portugal is established first. Secondly, the way in which Parliament and the legislative process work in Portugal is briefly addressed. This is followed by an analysis of the regulatory process of CAM. Particular attention will be paid to the extent to which the State sowed the seeds for CAM regulation. The political contest over CAM which entailed two attempts at statutory regulation will be then analysed. The main aspects of the content of the new Act that legislates on CAM in the country will be explored and the ad hoc Committee set up by the government to regulate on CAM presented.

5.2. Setting the Scene: the Portuguese Act 45/2003

On the 15th July 2003, the Portuguese parliament passed a new Act (nº 45/2003 – *Lei do Enquadramento Base das Terapêuticas não Convencionais*) which approved six CAM therapies: acupuncture, homeopathy, osteopathy, naturopathy, fitotherapy and chiropractic. This Act came into force on the 22nd August 2003. In May 2004, under this new Act, the setting up of a parliamentary ad hoc Committee¹⁵ was approved and tasked with ‘... studying and proposing the general parameters to regulate non-conventional therapeutics’ (ARP, 2003a:5391). In other words, this Committee was charged with the setting up of ‘... a structure for accreditation, training and certification of the professionals of non-conventional therapeutics’ (ARP, 2003a:5391).

This Committee has been in existence since 2004, as it has been extremely hard to reach an agreement on CAM regulatory proposals among its members. In 2007 the Committee submitted a descriptive report to the *General Directorate of Health (Direcção-Geral da Saúde – DGS)*, a key department in the Ministry of Health concerned with health policy and practice in the country. Since then, despite public discussion of this report, which was facilitated by the DGS later that year, little progress has been achieved. More recently, in July 2011, a Resolution Project (BE, Projecto de Resolução 42/XII) requesting clarification of the regulatory process for CAM was submitted to the Assembly of the Republic. In October 2011, this document was voted on and approved

¹⁵ This ad hoc Committee is known in the country as the Consultative Technical Committee on CAM - Comissão Técnica Consultiva das Terapêuticas não Convencionais (CTCTNC).

unanimously by all parliamentary MPs, who recommended that the government stipulate a new deadline for the implementation of the Act 45/2003. The DGS, in turn, presented to the Committee at the end of January 2012 a Bill Proposal on CAM regulation which, according to the CAM community, ignores the proposals prepared over the years by the Committee¹⁶. On the 1st February 2012 the Committee disclosed its legal opinion on the DGS' Bill Proposal, pointing to the lack of legitimacy of such a document and the usurpation of the Committee's functions. At the time of writing (June 2012), the CAM community is waiting for further governmental response (email from a traditional acupuncturist, May 2012).

So instead of the implementation of the new Act, the government has lengthened the regulatory process of CAM, and thus CAM therapies and CAM practitioners remain marginalised by the State. At the same time, acupuncture has been regulated by the Portuguese Medical Council (PMC), a competent authority responsible for the recognition, accreditation and registration of medical doctors, and which also oversees standards of medical practice. Acupuncture has become integrated into national conventional healthcare through the 'expertise' of 'medical acupuncturists', i.e. medical doctors who legally practise 'medical acupuncture'.

So despite the apparent rise of State interest in CAM in the country showed by the endorsement of CAM legislation, there have been some forces holding back that interest, as indicated by the fact that the new CAM legislation has not yet been implemented. In addition to this, acupuncture was legitimised by the PMC as a 'medical competency' in May 2002, while the statutory regulation process of CAM as a whole was still in progress. Currently, medical doctors are the only professionals with credentials to practise 'medical acupuncture' in Portugal, despite the increasing presence of traditional acupuncturists and CAM practitioners in general who have achieved self-regulation¹⁷.

The new Act 45/2003 is the result of a wide-ranging review process of earlier CAM Bill projects presented by two Portuguese political parties in a long and contested political

¹⁶ Available at: <http://apmt.weebly.com/legislaccedilatildeo.html> (Accessed on the 13th May 2012)

¹⁷ Although CAM legislation has not yet been implemented, the existence of CAM practitioners is acknowledged by the *Portuguese Classification of Occupations* 2010, a document produced by the *Statistics Portugal* (2011) (Instituto Nacional de Estatística – INE), a public institute supervised by the State. The document codifies and describes the work of 'specialists of traditional and alternative medicine', making special reference to the occupation of acupuncturists, of homeopaths and of naturopaths.

process which goes back to 1996. The analysis of this process may therefore be valuable in understanding the countervailing powers of the State, the political parties, the PMC and CAM, all of which have contributed to the passing of the new Act 45/2003. Before proceeding, it is worthwhile providing a brief overview of the way in which Parliament and the legislative process work in the country.

5.3. The Parliament and the Legislative Process in Portugal

Portugal, also known since 1910 as the Portuguese Republic, moved from a dictatorship to a parliamentary representative democratic republic in 1974. The country has four bodies exercising sovereign power: the President of the Republic, the Parliament (Assembly of the Republic), the Government and the Court (CEDEFOP, 2010). The Portuguese Parliament is a major source of political authority (Hopkin and Van Biezen, 2007), and ‘not only does it produce legislation and hold the government to account, it can also, as in other parliamentary systems, overturn a government through a simple absolute majority vote of no confidence’ (Hopkin and Van Biezen, 2007:105). The Members of Parliament (MPs) are elected by popular vote for four-year legislative terms, except if the President of the Republic dissolves the parliament and calls a general election.

The President of the Republic shares considerable power with the parliament and can dissolve the parliament and veto legislation (Hopkin and Van Biezen, 2007:106). In the case of a presidential veto, the President of the Republic should inform the Government of the reasons for doing so and should request a revaluation of the legislative Act¹⁸. While legislation enacted by the government is bound to comply with the presidential veto and the government must therefore introduce the amendments to the legislative act proposed by the President, legislation enacted by the Assembly of the Republic may override the veto. If this occurs, the President is required to promulgate the legislation within 8 days if it is again approved, without amendment, by a greater majority in the Assembly of the Republic¹⁹.

Four political parties have dominated the parliament: the left-of-centre *Socialist Party* (*Partido Socialista* – PS); the right-of-centre *Social-Democratic Party* (*Partido Social*

¹⁸ Available at: <http://www.parlamento.pt/Legislacao/Documents/Constitution7thRev2010EN.pdf> (Accessed on the 7th October 2011).

¹⁹ Available at: <http://www.presidencia.pt/?idc=1> (Accessed on the 7th October 2011).

Democrático – PSD); the left wing *Communist Party* (*Partido Comunista Português* – PCP) and the right-of-centre *Democratic and Social Centre – People's Party* (*Centro Democrático e Social – Partido Popular* – CDS-PP). Other parties with a smaller share of the seats in parliament are the Left wing Bloc (BE) and the left wing *Ecologist Party 'The Greens'* (*Partido Ecologista 'Os Verdes'* – PEV²⁰).

A Portuguese Bill has different names depending on whether it is introduced by the government (Bill Proposal) or by parliament (Bill Project). Once introduced to parliament, the Bill is always referred to a standing committee, which considers the Bill and may make amendments to it. Then, a parliamentary debate on the general principles of the Bill takes place, followed by a vote. If the Bill as a whole is voted on and approved, it is then debated and voted on clause by clause, whether in the parliament or in the standing committee (although there are some issues that can only be debated and voted on clause by clause by the parliament). The last version of the Bill is then subjected to a final general vote by the parliament. Once approved, the Bill becomes an Assembly of the Republic Decree. The Decree is then sent to the President of the Republic who enacts it as a Law and orders its publication (or instead exercises the right of veto). The new Law is then sent to the government to be signed by the Prime Minister (see Appendix 8, 'Simplified version of the Portuguese legislative process' page 324).

For the purpose of this chapter, there are two kinds of parliamentary committee: standing committees, which are specialised committees with permanent jurisdiction over specific matters; they are usually created at the beginning of each government and last for a legislative term; and ad hoc committees, established for a limited period of time and charged with a specific function which usually culminates in the presentation of a report²¹. Parliamentary committees and their scope are defined by the Assembly of the Republic and their members are appointed by all the Parliamentary groups (in accordance to their proportional share of the seats in the Assembly)²².

Having briefly presented the parliament and the legislative process in Portugal, it is now

²⁰ Although the left wing *Communist Party* (*Partido Comunista Português* – PCP) and the left wing *Ecologist Party 'The Greens'* (*Partido Ecologista 'Os Verdes'* – PEV) take part in parliamentary elections as the Democratic Unity Coalition (*Coligação Democrática Unitária* – CDU).

²¹ Available at http://www.en.parlamento.pt/ParliamentaryCommittees_XIIILeg/index.html (Accessed on the 7th October 2001).

²² Available at: http://www.en.parlamento.pt/Legislation/Rules_of_Procedure.pdf (Accessed on the 7th October 2011).

time to turn to the analysis of CAM legislation in the country. In the next section it will be shown how changes in the relationship between the State and CAM in the late 1990s facilitated a political contest about CAM regulation among the State itself, the political parties, the medical profession and CAM.

5.4. The State Sympathy for CAM Legislation in the Late 1990s

The new CAM legislation that currently exists in Portugal is the result of an unprecedented increase in governmental interest in CAM since 1996. Table 5.1 shows the sequence of main events since 1996 up to September 1999. These events show evidence of a change in the relationship between the Portuguese State and CAM.

Table 5.1: Timeline of the first political actions in relation to CAM legislation in Portugal

16 th April 1996	A working group on CAM legislation is set up under the remit of the DGS
November 1996	The DGS' working group starts sitting
16 th March 1999	The DGS' working group submits a CAM report to the DGS
29 th July 1999	A proposed Decree on the Medical Act is approved by the Council of Ministers
22 nd August 1999	CAM practitioners disseminate the DGS report
24 th September 1999	The proposed Decree on the Medical Act is vetoed by the President of the Republic

In March 1999, under the left-of-centre Socialist Party's government which had António Guterres as the Prime Minister, the *General Directorate of Health* (DGS) published a descriptive report on CAM worldwide and in Portugal. The report was produced by a working group made up of representatives appointed by the Ministry of Health in 1996. The publication of this report was very controversial and deserves to be explored in more detail. Although the report mentions the *National Federation of Natural Alternative Medicine's Associations* (FENAMAN – *Federação Nacional de Associações de Medicinas Alternativas Naturais*, an umbrella body for CAM associations in Portugal) as the main proponent for setting up the aforementioned working group on CAM, the latter group was formed with representatives of the DGS, the Medical and the Pharmaceutical Councils, the *General Directorate of High Education* (*Direcção-Geral do Ensino Superior*) and the *Department of Human Resources for Health* (*Departamento de Recursos Humanos da Saúde*), thus excluding any CAM representatives. Although the working group started its duties in November 1996, it took almost two and a half years for the group to finish and submit a report on

CAM to the DGS.

The DGS report on CAM clearly sowed the seeds for CAM regulation and created a suitable political soil to nurture CAM strategies to camicise health and healthcare. The report represents the beginning of CAM regulation in a variety of ways. Firstly, it embraces a public health policy agenda by stating the need to explore other 'knowledge areas' in health besides the one propounded by biomedicine, which can be either complementary or alternative to conventional medicine. The report identifies five representative CAM therapies: acupuncture, homeopathy, osteopathy, chiropractic and phytotherapy. Secondly, the report is sympathetic to the 'professionalisation' of CAM practitioners, by pointing to the need for CAM credentialism and for an appropriate CAM curriculum. As the Report states (DGS, 1999:41-42):

There was an overall agreement among the members of the working group that the quality of CAM education should be raised through the setting up of high standard courses and through the accreditation of those professionals with appropriate credentials. Therefore, an attempt to statutory regulate these [CAM] therapies should be done, in order to fight against the current anarchy [in CAM's practice].

Thirdly, the report highlights the fragmentation within CAM and the need to achieve greater cohesion. Fourthly, the report mentions the crucial role of the State in the successful integration of CAM into mainstream healthcare and in the protection of individuals' health. Fifthly, the report calls for the setting up of a Committee with representatives from the Ministry of Health, the Ministry of Education, the Medical and the Pharmaceutical Councils and CAM associations which should be tasked with drawing up statutory regulation for CAM and CAM practitioners (DGS, 1999).

Not surprisingly, this report was well received by the representatives of CAM associations, as it was in line with CAM's interests. Nevertheless, criticism of the 'scandalous lack of CAM representatives' within the working group and the references to the existence of internal pressures which made difficult 'the several ... attempts [of CAM associations] to be audited [by the DGS' working group]' (O Dia, 1999:11), were evident. The representatives of CAM associations also pointed to the fact that the Ministry of Health had kept the DGS report out of public view and was incomprehensively secretive about it from its publication on the 16th March 1999 until the Summer of the same year (O Dia, 1999:11), when CAM practitioners started

mobilising and disseminating its results.

Meanwhile, the various counteractions of the PMC to destroy the governmental ‘seeds’ for CAM regulation through the DGS report on CAM were significant. As the report itself discloses, most of the working group’s meetings were held ‘... without the presence of all the appointees due to a variety of reasons, and some of the appointees were substituted by others’ (DGS, 1999:4). In the end, all the appointees agreed and subscribed to the report, apart from the PMC’s representative, who did not agree with some aspects of the proposals for CAM regulation advocated in the Report. As Constantino Sakelarides, the DGS’ chairman at the time, reported in an interview with the Portuguese daily newspaper *Primeiro de Janeiro* on the 27th July 1999:

As is publicly known, a working group was set up and [its appointees] prepared over a long time a report which is currently with me. There is a concern with this report however, as there was no overall agreement among its members, as the Medical Council’s representative did not subscribe to the report. When an important institution like this one [the PMC] takes an attitude like this, we are placed in a very delicate situation, because the aim of the working group was to reach an agreement [on CAM]. (Fonseca, 1999)

This last quotation shows how this government leader was trying to avoid conflict with the medical profession by showing concern and tolerance for the PMC’s actions in not participating in an assessment of CAM legislation through the DGS’ report. In a way, the rhetoric of this leader showed loyalty to the medical profession, in that the ‘only’ problem of the DGS report was the fact that it was not signed and therefore ‘legitimised’ by the PMC. At the same time, Germano de Sousa, the PMC’s chairman at the time, stated in an interview released by the newspaper *Primeiro de Janeiro* in July 1999:

We [the PMC] haven’t yet assessed it [the DGS report] properly. We will assess it in due course but I believe that any conclusive evaluation [of the report] is far from being achieved. Furthermore, this report is just one amongst many others. Specifically, the big concern here is the need to protect Portuguese citizens from the manoeuvring of groups [CAM] without any scientific basis to treat diseases ... In other words, the money currently spent on health is precious and so cannot be wasted on [CAM] practices which are not scientifically proven. There are some «laboratories» which manufacture so-called homeopathic drugs but the latter are just water which have been sold like gold (Bessa, 1999a).

Evident in this last statement is the position of rejection of CAM legislation by the

PMC, with specific reference to homeopathic drugs. The depreciatory language used to refer to CAM and CAM practitioners is remarkable. This strategy by the PMC of ignoring governmental sympathy for CAM legislation was accompanied by the submission to the government in July 1999 of a proposed Decree on the Medical Act, which would establish the legal basis for medical practice and would constrain CAM practice in Portugal. The medical practice was defined by this Decree as an ‘activity involving diagnosis, prognosis, prescription and implementation of therapeutic measures regarding the health of people, groups or communities’ (SRNOM, 1999b). Furthermore, the proposed Decree comprised of medical practice: ‘medical exams and respective medical reports, as well as all the declaratory acts about the state of the health, illness or death of an individual’ (SRNOM, 1999b). This medical practice, in turn, according to the submitted document, would therefore be under the jurisdiction of those professionals who had graduated in medicine and who had registered as members of the PMC.

This proposed Decree was the seed for discordance between the government and the medical profession. Although approved by the Council of Ministers on the 29th July 1999, the Decree was vetoed by Jorge Sampaio, the President of the Republic, who pronounced it as unconstitutional, after a petition signed by six thousand people demanding the President not sign the Decree was submitted. The Decree was seen by the CAM community as impeding the activity of CAM practitioners in the country (The Portugal News online, 1999)²³. Not surprisingly, this governmental action caused much controversy. In November 1999 the North division of the PMC expressed its bewilderment concerning the presidential veto and amplified their attack on CAM:

We understand that the Government, through the Ministry of Health, wants to reduce health expenses, but it would be a tasteless joke if the patients could have access to consultations in a health centre or in the hospital setting with *a witch using a turban in front of a crystal ball and inspired by a set of [Tarot] cards instead of a medical doctor using a stethoscope and scientific criteria*. (SRNOM, 1999a, my emphasis)

In turn, representatives of the government, such as the ex-Minister of Health Paulo Mendo, in an interview to the *Primeiro de Janeiro* in July 1999, were reported as taking a more conciliatory point of view in relation to CAM legislation:

²³ Although some of the leaders interviewed in this research felt that the proposed Act was best seen as a strategic move in relation to nurses than to CAM practitioners.

Twenty years ago we thought that one medical doctor for 1500 people would be enough, but at present we have a medical doctor for 330 people and that is not enough, we need more. So, the medical doctors and conventional medicine will never have too few clients. What is really going on here [the interviewee is referring to the battle between the PMC and CAM associations] is a philosophical and a mentality problem. I do not subscribe to the opinion of many of my colleagues, I am totally open to CAM, I think they [CAM therapies] can be very useful in certain areas and should be regulated but I totally understand the lack of trust of the scientific medical community [towards CAM]. (Bessa, 1999b)

Finally, the views of representatives from CAM associations, such as Carlos Ventura, chairman of the *National Federation of Natural Alternative Medicine* (FENAMAN) at the time, regarding the Presidential veto, were reported in an interview to the newspaper *Euronotícias* in October 1999 that ‘the President of the Republic had to correct a governmental mistake’. Such representatives congratulated the ‘independent position’ of the President and claimed that the spirit of the Medical Act showed an intention to ‘appropriate’ CAM (Ventura, 1999). So one can see that, by the end of 1999, the DGS report and the presidential veto nurtured CAM interests and constrained the medical profession’s attempts to retain its dominant position within the healthcare arena. These governmental actions therefore sowed the seeds for a change in the balance of power within the healthcare arena.

To summarise, it seems that a new constellation of countervailing power groups arose within Portuguese healthcare by the end of the 1990s. The countervailing power of CAM practitioners was strong enough to persuade a State institution, the DGS, to prioritise a report on CAM. In turn, the Portuguese government, through the Ministry of Health and the publication of the DGS report on CAM, was sympathetic to CAM practitioners and camisation, and sowed the seeds for changing the position of CAM within mainstream healthcare. Governmental interest in CAM regulation, however, was at the same time a trigger for discordance with the medical establishment. The latter reacted to the growing governmental interest in CAM by proposing legislation on medical practice, which in turn failed to gain governmental approval. Furthermore, the allegiance of the DGS, an institution from the State, and the countervailing power of CAM practitioners created favourable conditions for the first political attempt to statutorily regulate CAM²⁴. This took place at the end of 1999, as we will see in the next section.

²⁴ Although it should be noted that CAM statutory regulation was earlier proposed by the Earth Party Movement (MPT), an environmentalist and rural Portuguese political Party founded in 1993.

5.5. The First Attempt at CAM Regulation

The most recent political attempt to regulate CAM in Portugal, which gave rise to the Act 45/2003, was in fact preceded by another, which failed as a result of a clash of the countervailing powers of the political parties and coincided with a short period of political instability in the country. Table 5.2 shows the timeline of the first attempt at CAM legislation.

Table 5.2: Timeline of the first attempt at CAM legislation in Portugal²⁵

7 th December 1999	The Left Bloc Party (BE) submits a CAM Bill Project (<i>Projecto de Lei n° 34/VII – Regulamentação das Medicinas não Convencionais</i>)
13 th December 1999	The BE Project is referred to a technical permanent <i>Commission on Health and Drugs (Comissão de Saúde e Toxicodependência – CHD)</i> which is charged with the revision, evaluation and approval of the document
13 th December 1999	The BE Project is also referred to a technical permanent <i>Commission on Education, Science and Culture (Comissão de Educação, Ciência e Cultura – CESC)</i> which is charged with the revision, evaluation and approval of the document
1 st June 2000	The BE Project is debated on and approved in general by parliament
1 st June 2000	The BE Project goes to the <i>Commission on Health and Drugs (Comissão de Saúde e Toxicodependência – CHTD)</i> for a second time, which is tasked with reviewing and elaborating a final version
25 th October 2000	The Socialist Party (PS) submits a CAM Bill Project (<i>Projecto de Lei n° 320/VIII – Lei do Enquadramento Base das Medicinas não Convencionais</i>)
26 th October 2000	The PS Project is referred to a technical permanent <i>Commission on Health and Drugs (Comissão de Saúde e Toxicodependência – CHTD)</i> which is charged with the revision, evaluation and approval of the document
Julho 2001	The PMC presents its official position on the BE and PS Projects on CAM legislation by submitting a report to the <i>Commission of Health and Drugs</i>
27 th December 2001	The BE project is debated on clause by clause by parliament and fails to gain approval
January 2002	The Prime Minister António Guterres resigns and parliament is dissolved
4 th April 2002	The BE and the PS Projects expire

The Left Bloc Party (BE) was the first party to submit a CAM Bill Project (BE, *Projecto de Lei n° 34/VII – Regulamentação das Medicinas não Convencionais*) to parliament on the 7th December 1999. The BE Party is one of the youngest and smallest

²⁵ See: <http://www.parlamento.pt/ActividadeParlamentar/Paginas/DetalheIniciativa.aspx?BID=6319> and <http://www.parlamento.pt/ActividadeParlamentar/Paginas/DetalheIniciativa.aspx?BID=5860>

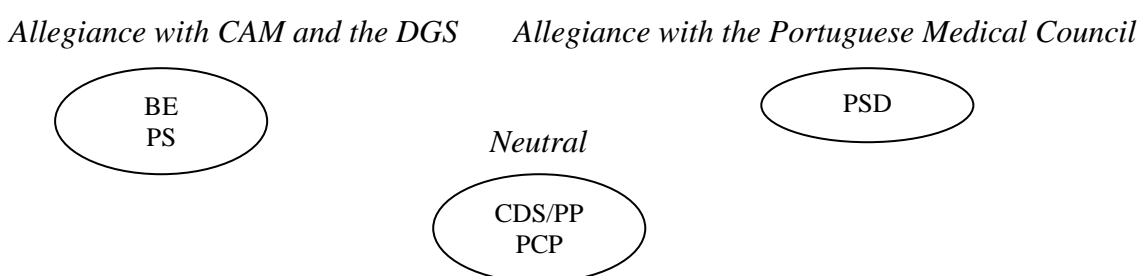
parties with eight MPs currently in the Portuguese parliament, and is popular for its proposals on controversial and sensitive issues such as domestic violence, abortion and women's rights, immigration, genetically modified food, and CAM regulation.

Nearly one year later, however, on the 25th October 2000, the Socialist Party (PS), the dominant left-of-centre party, also submitted a CAM Bill Project (PS, *Projecto de Lei n° 320/VIII – Lei do Enquadramento Base das Medicinas não Convencionais*) to parliament. Both CAM Bill Projects claimed there was an urgent need to start national statutory regulation of CAM. The main arguments in both documents were: lay use of CAM has increased in many Western countries; the need for CAM regulation has become a reality; medical interest in CAM has risen; and therapeutic pluralism in conjunction with public awareness of risks to health has acquired greater expression. Both Projects drew upon altruistic claims about patients' safety to legitimise the need for an assessment of CAM in terms of quality and efficacy. The PS document in particular takes a cautious approach to CAM regulation by stating that CAM practitioners and conventional medical doctors should try to find professional complementarity. As we can see, both projects embraced a public health policy agenda and proposed 'upstream' interventions on health (Hunter, 2003) where CAM could be beneficial. Both the BE and the PS' submission of CAM Bill Projects were thus suggestive of a strategic alignment with CAM's interests and, if approved, could therefore create the conditions to change the balance of power within the healthcare arena.

The core aim of these two CAM Projects was to create the first foundations for CAM legislation. Both Projects, the BE one in December 1999 and the PS one in October 2000, were acknowledged by the President of the Assembly of the Republic and were referred to a standing *Committee on Health and Drugs* (*Comissão de Saúde e Toxicodependência – CHD*) which was charged with the revision, evaluation and approval of the documents. Although the Committee approved both Projects, the PS Project did not proceed further in the legislative process due to a delay and the consequent expiry of the initiative. The BE Project, however, was reviewed, evaluated and approved by a second standing *Committee on Education, Science and Culture* (*Comissão de Educação, Ciência e Cultura – CESC*) and later debated on and approved in general by the parliament on the 1st June 2000. After this, the BE's document went to the CHD for a second time, which was tasked with reviewing and elaborating a final

version. This later version, however, although voted on clause-by-clause and approved by the CHD's working groups, and prepared for a final parliamentary vote, never acquired final approval, as the right-of-centre party PSD voted against it, and the right-of-centre CDS/PP and the left wing Communist Party PCP abstained on the BE proposed Act (ARP, 2003c). On the 4th April 2002, both BE and PS CAM projects expired and CAM regulation failed. The countervailing power divisions emerging from within the Portuguese State itself, here represented by the political parties, during this first attempt at CAM regulation in the country are illustrated in figure 5.1.

Figure 5.1: The Portuguese State and its countervailing power divisions concerning the first attempt at CAM legislation



Having provided the background to the failures of previously proposed CAM legislation, such legislative failures can now be evaluated. As was mentioned before, in the beginning of 2002, Portugal experienced political and economic instability. In January of that year, following a disastrous result for the Socialist Party in the local elections, the Prime Minister António Guterres resigned and so did the government. Such a politically unstable climate certainly did not help to achieve parliamentary consensus on 'marginal' issues such as CAM regulation. However, other core reasons concerning the failure of the first attempt were also pointed out by some politicians such as the BE Party's leader, Francisco Louçã. In an interview to the Portuguese TSF radio station (7/01/2002a), Louçã mentioned the close partnership between the right-of-centre Social-Democratic Party and the PMC on this matter, who he claimed were lobbying the regulators and also neglecting 'patients' rights in favour of business'. The Social-Democratic Party was even accused by some Left Bloc representatives of taking advantage of the political instability of the country by lobbying MPs to vote against this issue. In fact, in an earlier interview to TSF (18/10/2000), Germano de Sousa, the PMC's chairman at the time, dismissed the PS Project on CAM regulation by saying that it was 'absolutely unnecessary' and ironically admitted to not understanding the rush towards the regulation of CAM since there were '... many other issues that the

parliament should be concerned about'. When asked about the failure of CAM legislation as a consequence of the dissolution of the parliament, Sousa also remarked that:

Parties such as PSD and others recognised that CAM legislation hasn't been satisfactorily debated [in order to be regulated] and so the Left Bloc party was the only one who tried to bring it to the parliament. However, this matter [CAM regulation] has been delayed as there's no point in making it part of the political agenda now. (TSF, 7/01/2002b)

Although the PMC has traditionally been against CAM use and has not been enthusiastic about CAM statutory regulation, its discourse surrounding this has varied. For example, from 2000 onwards, the PMC's conflict with CAM associations gained new impetus. The leaders of the Council and of some CAM associations engaged in a professional battle by making offensive statements as well as strategic demands. CAM associations such as the *Committee for the Coordination of the Regulation of Naturology* (CCRN – *Comissão Coordenadora para a Regulamentação da Naturologia*), a now defunct umbrella body charged with the representation of CAM in the statutory regulation process, called in a radio interview (TSF, 18/10/2000) the Council 'autistic' and criticised its potential involvement in CAM legislation. As Jerónimo Sardinha (2000), the CCRN's chairman at the time, disclosed in a TSF radio interview:

The Medical Council has nothing to do with naturology and we do not have to bear its presence and arrogance within our own institution [the CAM Committee], as we do not claim that we should be present in institutions related to allopathic medicine. This [the PMC's involvement in CAM legislation] is a subordinate role which will not be accepted by our country. (TSF, 18/10/2000)

It is evident from this last statement that this CAM leader was attempting to separate CAM from the medical orthodoxy by rejecting the subordination of CAM practices to the medical profession. Strategically, he conveyed the idea that institutional medical power would be an obstacle to the future of the CAM Committee through the 'gaze' of the PMC's representatives, and would be as intrusive as CAM's interference in the PMC's affairs.

At the same time, the PMC's chairman, in June 2000, in response to the first general approval of the BE's CAM Bill project 34/VIII in parliament, stated provocatively in a

radio interview that he ‘understood’ this governmental action, since ‘what [CAM practice] has been free of legal punishment and practised by any quack [CAM practitioners] can now be regulated’ (TSF, 6/06/2000). He also disclosed that the Council was expecting to be consulted by the *Committee on Health and Drugs* on this matter and argued for the creation of an ad hoc Committee to report on CAM regulation, which would be constituted of medical doctors who would deliberate on CAM.

In the same radio interview, Sousa warned about two other Council’s concerns: the regulation and financial support of ‘quack medication’ and the need for scientific research on the latter; and the lack of CAM practitioners’ credentialism. In respect of the latter, Sousa argued that while medical doctors must undertake long and specialised university training, CAM practitioners usually undertake a course lasting up to two years (TSF, 6/06/2000). In light of this, the Council urged that a new debate on the legislation of medical practice was necessary alongside CAM legislation and claimed that it would be meaningless to define CAM without first drawing a boundary between it and ‘scientific medicine’.

Four months later, referring to the PS Project on CAM legislation, Sousa (TSF, 18/10/2000) disclosed in another radio interview that the Socialist Party had unfortunately not officially consulted the Council. Only informal contacts between the PMC’s chairman Sousa and João Sobral, one of the PS CAM project’s authors, had taken place. Furthermore, Sousa claimed that the Council’s involvement in the ad hoc Committee to regulate CAM would be pointless as this Committee would include ‘people without any kind of scientific knowledge’, who were ‘pseudomagicians’ (TSF, 18/10/2000).

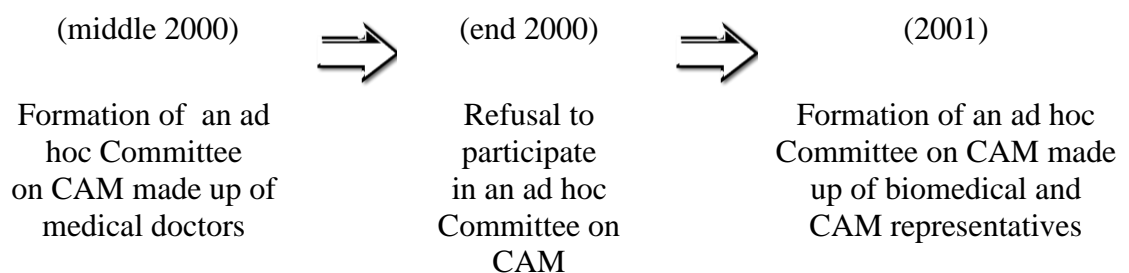
So by October 2000 the PMC’s rhetoric on CAM still involved strong rejection and deprecation of CAM by associating it with quackery and pseudomagic. And by the end of 2000 the Council had shifted from advocating a ‘biomedical’ Committee on CAM to sarcastically disregarding any such involvement if CAM practitioners became involved in this Committee. Later, in 2001, the PMC presented its official position on the BE and PS Projects on CAM regulation by submitting a report (SRNOM, 2001) to the *Committee of Health and Drugs*. The report outlined the PMC’s main objections to the Projects:

- (1) The use of the term ‘non-conventional medicines’. According to the report, ‘... there is only one medicine and the efficacy of any *self-proclaimed non-conventional therapy*, once scientifically proven, will be immediately incorporated into the medical canon’ (my emphasis). The Council proposes therefore to designate the term ‘complementary therapeutics’ to these therapies;
- (2) Furthermore, the report claims that representatives from the Ministry of Health, the Ministry of Education and the PMC and from each CAM therapy should be integrated in the technical committee. Furthermore, CAM representatives should be individuals with recognised merit within their therapy and should have CAM accreditation by the European Union;
- (3) The report declares that both Projects do not make a clear distinction between those therapies with scientific evidence and those which are quackery and do not have any scientific basis;
- (4) The report claims that only acupuncture, osteopathy and chiropractic should be regulated, since these are the only ones with scientific evidence for specific medical conditions;
- (5) The report states that the process of diagnosis and prescription are under medical jurisdiction, and clinical autonomy should not therefore be accorded to CAM practitioners; the report also emphasises that CAM practitioners should not be allowed to prescribe;
- (6) Whilst the report underlines that medical doctors should refer patients to CAM practitioners, it maintains that the latter should be aware of the limitations of their practice. In cases of acute illness for example, CAM practitioners should immediately refer patients to scientific medicine;
- (7) Finally, the report claims that CAM practitioners should not be allowed to manufacture or commercialise any products or instruments prescribed or used by their therapy.

So the Council’s position on its involvement in CAM legislation appears to have changed again with the submission of this report. Although the PMC’s traditional position rejected CAM, this last report indicates the endorsement of ‘CAM poaching’ (Boon et al., 2004), i.e. the incorporation of ‘the ‘best’ or ‘scientifically proven’ CAM treatments within the jurisdiction of medicine in a bid to eliminate the need for CAM practitioners’ (Boon et al., 2004). For example, CAM therapies are redefined as ‘complementary therapeutics’, contrasting them with the WHO’s recommended terms

of ‘complementary and alternative medicine’ or ‘traditional medicine’. Furthermore, acupuncture, osteopathy and chiropractic are acknowledged by the medical report as CAM modalities deserving recognition due to their scientific evidence base for certain treatments. Scientific evidence is therefore used in this report to legitimise some aspects of CAM. Having established the scientific credentials, CAM modalities are expected to transform themselves into ‘just one more therapeutic resource’ which can then be incorporated into the biomedical canon (Boon et al., 2004). Furthermore, the report can be seen as an attempt to protect established medical practices, such as diagnosis and prescription, by advocating that these practices should remain under the authority of orthodox medicine. Finally, the report shows the Council’s move from refusing to be involved in a future CAM Committee to a more conciliatory approach, proposing a future Committee which should include representatives from mainstream healthcare, the PMC and the six CAM modalities. Figure 5.2 illustrates the changing position of the PMC concerning the creation of an ad hoc Committee to regulate CAM over time. It shows that the PMC initially agreed to participate in a Committee constituted of medical doctors who would deliberate on CAM; however it rapidly changed its position and refused any involvement with the ad hoc Committee in light of the political disregard of the consultative services of the PMC, and eventually suggested an ad hoc Committee made up of biomedical and CAM representatives.

Figure 5.2: The counteractions of the Portuguese Medical Council towards the ad hoc Committee on CAM



This 2001 medical report was therefore the strategy opted for by the medical profession to counteract the governmental interest in CAM. It provides an insight into the PMC’s attempt to move from a position of rejection to a position of ‘incorporation’ (Saks, 1995a) or ‘co-option’ (Baer, 2001) of CAM into the biomedical model, by opening the door to some of CAM’s ‘scientifically based’ therapies namely acupuncture, osteopathy and chiropractic. Also, the claims presented in this medical report appear to have impacted on later political actions and on the new CAM legislation itself, with the latter echoing some of the report’s views, as we will see in section 5.7. We should now turn to

the analysis of the second attempt at CAM legislation.

5.6. The Second Attempt at CAM Regulation

Table 5.3 shows the timeline of the second attempt at CAM legislation in Portugal. After Guterres had resigned, on the 6th April 2002, the right-of-centre PSD Party won the general election under the leadership of Durão Barroso. On the 21st May 2002, the Left Bloc Party reintroduced the debate on CAM regulation by submitting a new Bill project (BE, Projecto de Lei nº 27/IX – *Regime Jurídico das Terapêuticas não Convencionais*), which was largely based on the previous bill. This revived project reinforced the need for CAM regulation by drawing upon WHO's reports on CAM. It also contained conceptual developments such as the replacement in the title of the word 'medicines' by the word 'therapeutics'. By attempting to gain the sympathy of the PMC, this strategic change can be seen as an attempt by the BE's leaders to increase its political influence over national government policy.

Table 5.3: Timeline of the second attempt at CAM legislation in Portugal²⁶

6 th April 2002	The right-of-centre PSD Party wins the general election under the leadership of Durão Barroso
21 st May 2002	The Left Bloc Party submits a new CAM Bill project (Projecto de Lei nº 27/IX – <i>Regime Jurídico das Terapêuticas não Convencionais</i>)
May 2002	Acupuncture is recognised by the PMC as a 'medical competency'
18 th March 2003	The Socialist Party (PS) submits a new CAM Bill Project (Projecto de Lei nº 263/IX – <i>Lei do Enquadramento Base das Medicinas não Convencionais</i>)
20 th March 2003	The right-of-centre CDS-PP party introduces a resolution project on the regulation of osteopathy (Projecto de Resolução 135/IX – <i>Regulamentação da Osteopatia</i>)
27 th March 2003	The BE and PS CAM projects and the CDS-PP resolution project go to a permanent <i>Commission of Employment and Social Affairs</i> , which is tasked with reviewing them and producing a joint text on CAM regulation
15 th July 2003	The new joint text, or a new version of a CAM Bill-project (Decreto da Assembleia 128/IX <i>Lei do Enquadramento Base das Terapêuticas não Convencionais</i>), is debated both on its general principles and clause-by-clause, and finally voted for unanimously by all parliamentary MPs.
15 th July 2003	The Portuguese parliament passes a new Act (nº 45/2003 – <i>Lei do Enquadramento Base das Terapêuticas não Convencionais</i>)
22 nd August 2003	The Act nº 45/2003 is issued in the Diary of the Republic

²⁶ See: <http://www.parlamento.pt/ActividadeParlamentar/Paginas/DetalheIniciativa.aspx?BID=19033> and <http://www.parlamento.pt/ActividadeParlamentar/Paginas/DetalheIniciativa.aspx?BID=19596>

Almost one year later, on the 18th March 2003, the PS Party also introduced a new Project on CAM regulation to parliament, which was similar to its previous submission (PS, Projecto de Lei nº 263/IX – *Lei do Enquadramento Base das Medicinas não Convencionais*). This Project mentioned the useful insights provided by the political debate on the previous CAM projects, as the latter allowed a better understanding of CAM status in the country and reinforced the need for CAM legislation. During this same month, the right-of-centre party CDS-PP introduced a resolution project on the regulation of osteopathy (CDS-PP, Projecto de Resolução 135/IX – *Regulamentação da Osteopatia*). When asked why the party had only focused on osteopathy, Nuno Teixeira de Melo, a CDS-PP's MP, argued that:

... amongst all the non-conventional medicines, osteopathy is one of the most advanced, has acquired scientific evidence and has been proven to be a complementary [therapy] to conventional medicine. (Assembleia da República Portuguesa, 28/03/2003c)

In this last statement scientific evidence is used at a political level to legitimate osteopathy. Furthermore, the complementary nature of osteopathy is highlighted.

At the end of March 2003 these three documents went to a standing *Committee of Employment and Social Affairs*, which was tasked with reviewing them and producing a joint text on CAM regulation. On the 15th June 2003 this joint text was debated both on its general principles and clause-by-clause, and finally voted for unanimously by all parliamentary MPs. The next stage was the creation of a Decree (ARP, Decreto nº 128/IX – *Lei do Enquadramento base das Terapêuticas não Convencionais*), its endorsement and the creation of the new Act 45/2003.

In summary, the second attempt at CAM legislation and its successful outcome with the creation of the new Act, was undertaken over a very short period and suggests a convergence of the positions of the different political parties regarding CAM legislation. In this sense, this second attempt helped solidify the allegiances between the political parties, the State and CAM and demonstrates a clear shift in the State position towards CAM. We will now turn to the analysis of the content of the new Act 45/2003.

5.7. The Content of the Act 45/2003

The new Act 45/2003 put six CAM therapies on the road to statutory regulation. Its

content contains some important aspects that are worthwhile mentioning. Firstly, it denotes the influence of the PMC. For example, the new Act suggests a new and specific socio-political concept – ‘non-conventional therapeutics’ – discarding the use of the term ‘medicine’. This new term has become commonplace within CAM political and professional circles since 2003 and is applied to those therapeutics which ‘... depart on different philosophical grounds from conventional medicine and use specific processes of diagnosis as well as their own therapies’ (ARP, 2003a:5391).

The definition of ‘non-conventional therapeutics’ is legitimated in the Act through reference to the reports of the WHO on CAM. By drawing on the WHO’s definition of CAM, this new Act appears to demarcate CAM from conventional medicine as well as to encourage CAM’s occupational closure. This CAM definition legitimates CAM therapies as different from biomedicine and as having professional autonomy from the medical profession. However, despite this aspect playing in favour of CAM, the document underlines five orienting ethical standards of CAM, some of which have been influenced by the PMC’s earlier claims:

- (1) The users’ right to an informed choice of CAM based on its quality, efficacy and potential risks;
- (2) The protection of public health, by respecting the rights of the individuals to safeguard their health;
- (3) The protection of users, which demands high levels of responsibility, diligence and competence, acquired through the professional qualification and accreditation of CAM practitioners;
- (4) The protection of the well-being of users, which encompasses the complementarity of CAM with other healthcare professions;
- (5) The promotion of scientific evidence based research on the six specific CAM therapies as a way to achieve higher quality, efficacy and effectiveness levels.

The Act still states that only professionals holding legal and accredited qualifications can practise CAM. However, unlike the Council’s position, this new Act also recognises the clinical autonomy of CAM practitioners. Therefore, the idea of the potential subordination of CAM to the medical profession is not explicitly contemplated in the new CAM legislation. Despite being in favour of CAM, this specific clause on CAM’s clinical autonomy has turned CAM legislation into a much longer and messier process,

as the autonomy of CAM practitioners remains a controversial issue within medical orthodoxy, both at a collective and individual level.

After the creation of the new Act 45/2003, an ad hoc Committee charged with CAM regulation was set up. We should now turn to the next section and look at this Committee in more detail.

5.8. The Ad Hoc Committee on CAM Legislation

In May 2004, an ad hoc Committee (CTCTNC) tasked with regulating CAM was created (ARP, *Despacho Conjunto n° 327/2004*) and in March 2005 the Committee's members were appointed by the government (ARP, *Despacho Conjunto 261/2005*). The dynamics within this new Committee on CAM and the timeline of the governmental and political actions in relation to it are worthy of mention and are illustrated in table 5.4 below. This Committee initially comprised 16 members: (six CAM representatives, seven healthcare professionals and academics recognised by the State, and three representatives of government (from the Ministry of Health, the Ministry of Education and the Ministry of Science, Innovation and High Education). These committee members were appointed by the *General Directorate of Health* (DGS) and approved by the aforementioned three Ministries involved in CAM legislation.

Table 5.4: Timeline of the governmental and political actions after the setting up of the ad hoc Committee on CAM

28 th May 2004	An ad hoc Committee is set up and tasked with the regulation of CAM (Despacho Conjunto n° 327/2004)
18 th March 2005	The Committee's members are appointed by the government (Despacho Conjunto n° 261/2005)
December 2007	The Committee hands in to the DGS its proposals on CAM regulation
June/July 2008	Public discussion on the Committee's proposals on CAM regulation takes place
31 st December 2008	The material from the public discussion is sent to the Committee who is charged with the elaboration of a final report
19 th June 2009	A request by a rank-and-file acupuncturist to have access to the Committee's documents is sent to the DGS
20 th July 2009	A complaint is made by a rank-and-file acupuncturist to the Committee for the Access of Administrative Documents (CADA) about the lack of the DGS' response (Case n°/Processo n° 406/2009)
7 th October 2009	The CADA publishes its legal opinion on the DGS' lack of response regarding access to the Committee's material (Opinion/Parecer n° 261/2009 to the Case n°/Processo n°

	406/2009)
17 th October 2009	The Left Bloc Party (BE) submits a Query n ^o 299/XI/1 to the Ministry of Health
28 th October 2009	Five new Committee members are appointed by the government to replace 4 members who withdrew from the Committee and one member who had died
22 nd April 2010	The Ministry of Health replies to the BE's Query n ^o 299/XI/1
29 th July 2011	The BE submits a Resolution Project (Projecto de Resolução n ^o 42/XII/1 ^a)
9 th November 2011	The Assembly of the Republic publishes the Resolution 146/2011 – <i>Recomenda ao Governo a Regulamentação da Lei n.º 45/2003, de 22 de Agosto, relativa ao enquadramento base das terapêuticas não convencionais</i>
January 2012	The DGS presents a Bill Proposal on CAM to the Committee
1 st February 2012	The Committee sends its legal opinion on the DGS' Bill Proposal
16 th February 2012	The BE party requires an audition with the DGS' chairman to discuss the regulatory process of CAM

It took around two years for the Committee to hand in its proposals on CAM regulation to the DGS. As mentioned earlier, the Committee witnessed the withdrawal of some conventional healthcare representatives, as well as several disagreements among CAM representatives and CAM associations. For example, the representative of the Ministry of Health in the Committee who was also the Committee's first chairman, Emílio Imperatori, resigned in 2009 and no replacements have yet been appointed. Although the Committee's proposals on CAM legislation were submitted to the DGS, analysis of association websites and newsletters has suggested the presence of strong clashes of opinion and lack of cohesion among the appointees. On the one hand, the PMC and CAM associations have entered into an uninhibited battle which has contributed to the hold-up of CAM regulation in the country. On the other hand, the disagreements among CAM representatives have also been significant. Clashes between the representatives of CAM on the Committee and CAM associations have become public, mainly on issues such as credentialism-making.

Since the public discussion of the Committee's proposals on CAM regulation in June/July 2008, which was under the remit of the DGS, little progress has been made. In December 2008 the material resulting from the public discussion was sent by the DGS to the Committee, and the latter was charged with the elaboration of a final report on the public proposals and comments. This final report has not as yet been submitted. In June 2009 a request by a rank-and-file acupuncturist to the DGS to have access to and consult the material submitted to the Committee was made. The DGS, in turn,

transferred the decision over this requirement to the Committee itself. In the face of the lack of response from the Committee, in July 2009 a complaint to the *Commission on Access to Administrative Documents (Comissão de Acesso aos Documentos Administrativos – CADA)*²⁷ was made by the same rank-and-file acupuncturist. In October 2009 the CADA disclosed its legal opinion on the lack of response of the DGS (Parecer n° 261/2009; Processo n° 406/2009), stating that access can only be denied to documents produced within less than one year. Three months later, in October 2009, the Left Bloc Party (BE) submitted the following four queries to the Ministry of Health (BE, *Query 299/XI/1 - Desrespeito pelo Parecer da CADA, relativo à Divulgação de Documentos Produzidos no âmbito do Processo de Regulamentação das TNC*):

- Could the Ministry confirm if a final report on the public discussion of CAM regulation was published?
- If yes, why has the report not been made public?
- Does the Ministry of Health reject the CADA's opinion (Parecer n° 261/2009) or agree with it [allowing thus access to the documents]?
- What is the expected date for the implementation of the Act 45/2003?

More recently, in July 2011, the BE submitted a Resolution Project (BE, Projecto the Resolução n° 42/XII/1) to parliament, recommending the implementation of the Act 45/2003. This document emphasised the long delay of CAM regulation in Portugal (at the time of its submission, eight years had passed since the enactment of the Act 45/2003) as well as the absence of the ad hoc Committee's chairman, who had resigned after the report on the public discussion of CAM regulation had been published in the end of 2009. This Resolution Project was approved and published by the Assembly of the Republic (APR, Resolution 146/2011), which advised the government to complete the regulation process of CAM. The government, in turn, recently announced its Bill Proposal on CAM regulation (DGS, 2012), and made clear the need for the creation of professional credentials of CAM practitioners as well as online registration of credentialed practitioners in the country, which should be under the remit of *The Central Administration of the Health System (Administração Central dos Sistemas de Saúde, I.P. – ACSS)*, a public institution under the supervision and guardianship of the Ministry of Health (TSF, 1/02/2012). Furthermore, it clearly states that CAM professionals cannot claim their acts as curative. This recent Bill Proposal has been

²⁷ An independent public body which works with the Assembly of the Republic and is responsible for the compliance with the legal provisions on access to administrative information.

subject to many critiques by the CAM community, who has claimed that such document simply ignores the work done over the years by the ad hoc Committee and is a usurpation of the Committee's rights to regulate on CAM. So, it can be concluded that CAM regulation in Portugal has been a very hectic process. On the one hand, the countervailing power of CAM, the medical profession and the State has endured since 1996; on the other hand, the regulation process of CAM has given rise to internal fragmentations within CAM, the medical profession and the State themselves which have unveiled different internal interests and priorities and have helped little with the termination of this process.

Having exposed the political contest around CAM regulation since the late 1990s, the reasons why the Portuguese state is regulating six CAM therapies can now be evaluated. Why has the Portuguese State given CAM the chance to enter the conventional healthcare market, in spite of the generally negative response of the medical elite? It could be said that the new CAM Act, if implemented, would provide a way forward with regard to the status of CAM in Portugal. This Chapter has suggested two main drivers of this legislative support: the mobilisation of CAM practitioners to acquire statutory regulation by triggering State sympathy for CAM legislation; and the countervailing powers of different political parties which pressurised the State towards CAM legislation. Both CAM practitioners and political parties acted as countervailing powers as both sought to challenge the existing order within healthcare and to bargain power and status with the State, other political parties and the medical establishment.

The Portuguese State itself, in turn, has had its own interests. For example, it has been under pressure to cut public expenditure and to increase the efficiency of the healthcare system. In 2004, the Organization for Economic Co-operation and Development's (OECD) *Economic Survey of Portugal* (2004:7) emphasised the fact that the reform of the Portuguese healthcare system must contain additional measures such as the enhancement 'of the medical prevention and early detection of illnesses, which tend to improve health outcomes and reduce costs of healthcare associated with late detection'. This has led to a revaluation of the expansion of scientific medicine and also to a growing governmental concern with public health policy and alternative ways of providing healthcare, as mentioned by the 1999 DGS' report on CAM. Illness prevention has therefore been an area where CAM modalities such as acupuncture or homeopathy have claimed the right to have a voice.

Finally, actions by the Portuguese government seem to be in line with international health organisations. The promotion of CAM legislation by supranational organisations such as the WHO and the *Council for Europe*, and the publishing of regulatory policies on CAM by these international bodies have encouraged national States to change their attitude towards CAM therapies and to open the door to some of them, by regulating and integrating them within national healthcare systems. These organisations have attempted to take health policy-making in a different direction by concentrating not only on the evidence-based medicine (EBM) approach and on the acute hospital care but also on a public health approach and on its broader conception of health (Hunter, 2003). This broader conception of health includes the emphasis on prevention and on public awareness of individual risk factors and lifestyle choices to health, two fields where CAM therapies have claimed their stakes, as was shown in Chapter Four.

5.9. Discussion

This chapter has addressed the following research questions: (1) To what extent has the Portuguese political context sustained the success of CAM practitioners' strategies? (2) To what extent have CAM practitioners and the medical profession influenced State policy in Portugal? In line with Kelner et al. (2006), the analysis presented in this Chapter has attempted to contribute to the countervailing powers model (Light, 1995, 2000) in that it looks at CAM strategies as being employed in a field force of countervailing powers. CAM has interacted with interdependent partners such as the political parties, the State and the medical profession since 1996. These have been major partners with different interests and goals which have been in tension with each other and who have exercised actions to counterbalance power and status within the healthcare market.

This chapter started depicting the present scenario of CAM legislation in the country. The role of the government as having sowed the seeds for CAM regulation in the late 1990s by publishing a report showing the need for CAM legislation has been presented. This governmental action encouraged political contestation on CAM statutory regulation between the institutional power of the State, the political parties, the medical profession and CAM since the late 1990s. The findings outlined here suggested that the actions of CAM in pursuing statutory regulation and in fulfilling therefore its own interests have resulted in the creation of the new Act 45/2003 which regulates six CAM therapies in the country. CAM thus has stimulated unprecedented political and

governmental interest. By creating this Act, the Portuguese State showed itself to be sympathetic to CAM legitimacy and to camisation in the country. To conclude, CAM's relationship with the State has clearly changed.

CAM has acted as a countervailing power in that it has shown significant impact on State policy-making process. The New Act 45/2003, although calling for a scientific model of CAM, is sympathetic to CAM and CAM practitioners. It approves CAM autonomy and does not restrict the practice of CAM to the medical profession. It is oriented to legitimise new healthcare professionals who should comply with the standards of a 'profession', by seeking professionalisation: the call for CAM's 'occupational' and 'institutional' credentialism (Freidson, 1986) and for CAM's professional ethics present two good examples of this. This political soil has thus been suitable to nurture CAM strategies presented in Chapter Four. In this environment, CAM should have the conditions to thrive and to fulfil their own interests in spreading and acquiring control over camisation.

Nevertheless, the new CAM legislation also reflects the influence from the countervailing power of the medical profession. The reaction of the medical establishment to CAM's attempts at statutory regulation has varied. At the end of the 1990s, the PMC at first resisted CAM's counteractions to influence governmental power by promoting the issue of CAM in the political agenda. In June 2000, however, the Council sought to include a 'biomedical gaze' (Foucault, 1973) in CAM legislation, although in October of the same year it refused to get involved in the legislation of CAM. Eventually, in 2001, the Council again attempted to exert its 'biomedical gaze' over CAM legislation, despite its general hostile position in the CAM legislation process. Nevertheless, it accepted acupuncture as a 'medical competency', as we will see in more detail in Chapter Six. To conclude, CAM's relationship with the medical establishment has changed, as the latter has moved from a position of rejection to a position of incorporation of specific CAM therapies.

Alongside these volte-faces of the medical establishment to CAM's statutory regulation, the PMC seems to have impacted on State policy-making. For instance, the Council's claims over the ownership of the word 'medicine' impacted on the government's wording of the new CAM Bill, which included the term 'non-conventional therapeutics' instead of 'CAM' and the former became a commonplace term in Portugal. This

adopted term greatly differs from the terms used by international organisations such as the WHO and the *Council of Europe*, where the term ‘complementary and alternative medicine’ prevails. So, in Portugal medical power has been sufficiently strong in persuading the State to act in the medical profession’s own interests. The creation of a Committee to regulate CAM follows the advice of the PMC and provides the opportunity for the latter to exert a ‘biomedical gaze’ over the Committee, with seven out of thirteen appointees of the Committee comprising conventional healthcare representatives. Finally, the new Act 45/2003 also adopts the rhetoric on the need for a scientific evidence base of CAM.

Supranational institutions have also acted as countervailing powers in this process and have allied themselves to CAM. The guidelines on CAM such as those formulated by the WHO appear to be sympathetic to the integration of CAM in mainstream healthcare worldwide. Furthermore, the WHO also recommends adequate credentialism of CAM practitioners, as well as increasing collaboration between conventional healthcare professionals and CAM practitioners. The Portuguese government is thus in a challenging position, having to mediate between implementing guidelines from the WHO and negotiating the biomedical dominance and the strong corporate medical power in the country. It has adopted a very cautious position by trying to harmonise the relationship between these groups. Despite having sowed the seeds for CAM regulation, the DGS, the governmental body charged with CAM scrutiny, has indulged in legitimating CAM. The role of the DGS has been difficult as this governmental body needs to respond to the divergent claims from CAM, the WHO and the medical profession. It has not acted promptly and has been powerful enough to hold-up and consequently to delay the issue of CAM legislation. Although a big move has been made with the creation of a new Act 45/2003, CAM legislation has not yet been implemented and CAM professionals remain professionally marginalised and stigmatised in the country by other healthcare professionals. Such long delay has constrained camisation and has not put CAM in a better position to fulfil its interests. So camisation has taken place within a political context which has not given CAM practitioners the resources they would need to succeed in their strategies. Furthermore, by holding up CAM regulation, the State has allowed the medical establishment space to manoeuvre by consolidating ‘medical acupuncture’ in the country and by promoting an incorporationist approach of this therapy within mainstream healthcare, without the threat of the ‘expertise’ of legitimised traditional acupuncturists.

Having dealt so far with the political context under which CAM strategies have been employed, it is now an opportune time to turn to another issue which is crucial to the analysis of the contemporary relationship between CAM and the medical profession: the differential interest in CAM by the medical establishment. One consequence of the process of camisation undertaken by CAM practitioners has been the growing sympathy of the medical profession to CAM. This sympathy however has gone hand in hand with an attempt to take control over camisation by incorporating CAM into the biomedical practice, as the creation of a competency in 'medical acupuncture' has shown. In Chapter Six the institutional medical response to CAM, which has shift from a position of total rejection to a position of restricted reception of CAM, is analysed. We will see this shift by analysing and comparing two CAM therapies, acupuncture and homeopathy.

CHAPTER SIX²⁸

THE DIFFERENTIAL INCORPORATION OF CAM INTO THE MEDICAL ESTABLISHMENT: THE CASE OF ACUPUNCTURE AND HOMEOPATHY

6.1. Introduction

In Chapter Five the Portuguese political context within which CAM practitioners have employed their strategies was analysed. It was shown that the relationship between CAM and the State has changed, as the new legislation on the former reveals. The medical establishment in turn has shifted from a position of rejection to a position of incorporation (Saks, 2005a) or co-option (Baer, 2001) of CAM. CAM, however, is a broad field and is made up of many therapies with their own, sometimes unrelated, beliefs and philosophies. It is therefore of interest to know the extent of CAM incorporation into the Portuguese medical establishment, by comparing two CAM therapies, acupuncture and homeopathy.

Sociological research which draws on social closure theory has suggested that the countervailing power of CAM in relation to mainstream healthcare has posed particular challenges to biomedical practice (Kelner et al., 2004; Saks, 2003; Wolpe, 1985), as it represents one more competitor in the market. Recent conceptualisations such as ‘incorporation’ or ‘co-option’ have been attempts to analyse recent biomedical closure towards CAM. Amongst all of the CAM therapies, acupuncture is often regarded as a paramount example of a CAM therapy that has been incorporated or co-opted by biomedicine. Saks (1995a, 1995b, 1994), for instance, has suggested that the British Medical Association has moved from a long-standing position of rejection to a ‘tacit’ incorporation of acupuncture. In other words, acupuncture has been biomedicalised (Baer et al., 1998b), i.e. transformed into a ‘biomedical technique’ isolated from its wider theoretical framework of Traditional Chinese Medicine, and restricted to areas where conventional medicine has not been very successful (Dew, 2000). Baer (2004), in turn, has portrayed acupuncture in the USA as a professionalised heterodox medical system which has been granted legitimacy, but at the cost of a subtle process of co-option or absorption by biomedicine. Similar scenarios can be observed in countries like New Zealand (Dew, 2000), Norway (Norheim and Fønnebø, 1998), Israel (Bernstein and Shuval, 1997), Germany (Frank and Stollberg, 2004; Frank, 2002), Canada (Welsh

²⁸ The material from this chapter has been recently published (Almeida, 2012) and a copy of the paper is included in the appendices.

et al., 2004), Argentina (Freidin, 2010) and Brazil (Nascimento, 1998).

Sociological research has not been as established on homeopathy as on acupuncture; however, it is apparent that this therapy has achieved higher status within Western mainstream healthcare. As Van Haselen (2005:229) has clearly put it, the Western debate on homeopathy within biomedicine has moved from 'should homeopathy be present at all' to 'how homeopathy should be integrated into the medical system as a whole'. Cant and Sharma (1996a), for instance, have shown how homeopathy in the UK has moved from a position of marginality to one of 'enhanced legitimacy'. For example, in the UK the *Faculty of Homeopathy*, a professional body for medical doctors and other mainstream healthcare professionals, accredits postgraduate training courses in this therapy which are restricted to those professionals²⁹. Further, four hospitals provide homeopathic treatments on the NHS³⁰ and in 2006 homeopathic over-the-counter remedies for some conditions were made available to the public (Samarasekera, 2007). Outside Europe, in Brazil for instance, homeopathy has been incorporated as a medical speciality since 1980 (Akiyama, 2004). Interestingly, this was before acupuncture which was incorporated fifteen years later (Akiyama, 2004). According to the *European Committee for Homeopathy*, the Medical Councils from countries such as Germany, Switzerland, Austria, Hungary, Romania and Spain have also recognised the medical practice of homeopathy³¹.

Nevertheless, this incorporation by biomedicine of acupuncture and homeopathy has gone hand in hand with the ongoing debate over their scientific evidence based efficacy. Recent sociological research on the persistence of medical resistance towards CAM often refers to the idea propounded by the medical profession that CAM does not have a scientific evidence base as the most convenient argument to exercise occupational closure (Kelner et al., 2004; Callahan, 2002). This has been illustrated particularly through the case of homeopathy in some Western countries. Even in countries where homeopathy has enhanced its legitimacy, there are periodic resurgences of medical concern about the scientific validation of this therapy, which is seen as being grounded on irrational premises which violate the traditional concept of science (Degele, 2005). This concern has been evident in the UK, for instance, with the recent publication of the

²⁹ Faculty of Homeopathy website. Available at: <http://www.facultyofhomeopathy.org/training/> (Accessed on the 29th June 2010)

³⁰ British Homeopathic Association website. Available at: http://www.britishhomeopathic.org/getting_treatment/service_providers.html (Accessed on the 29th June 2010)

³¹ <http://www.homeopathyeurope.org/regulatory-status> (Accessed on the 29th June 2010)

House of Commons' *Science and Technology Committee's Second Evidence Check Report* on homeopathy (House of Commons, 2010) and the subsequent British Medical Association's resurgent concern about the controversial efficacy of this therapy, with propositions to ban it from the National Health Service (Nursing Times.net, 2010) and to label homeopathic remedies as 'placebos' (Devlin, 2010).

Scholars have argued that, if on the one hand biomedicine insists on scientific research on CAM, on the other hand CAM claims a lack of the socioeconomic opportunities for carrying out evidence-based research on its efficacy (Saks, 2001). On the surface, CAM retains a lower level of scientific proof and so can be easily excluded from the medical establishment, which is now predicated on such evidence. The biomedical ideal of practice being scientifically based has been successful, as the development of evidence-base medicine (EBM) has shown.

Previous research, however, has suggested that EBM has not been the sole sponsor of biomedical power (Van der Geest and Whyte, 1989). Elliott (2004:125), for instance, has suggested that scientific impartiality in biomedicine has been spoilt by the possibility of biomedicine attaining financial gain in its relationship with the pharmaceutical industry. Light's (2005; 1995) concept of 'countervailing powers' provides a useful insight into the analysis of the relationship between CAM, the medical profession and the pharmaceutical industry. As showed in Chapter Five, this notion refers to the counter-moves of powerful actors to redress the imbalance of power '... in a field in which they are inherently interdependent yet distinct' (Light, 2005:216). It would therefore be of interest to know, for instance, whether the emerging interest of the pharmaceutical industry in homeopathy can be sufficient to imbalance its state of power with biomedicine, to enhance the medical status of homeopathy and to make the latter amendable to biomedicine in countries where this therapy remains rejected.

It has been argued in this chapter that although acupuncture and homeopathy have been incorporated by biomedicine, they remain a concern to the medical orthodoxy. Moreover, the biomedical co-option of homeopathy has been irregular, with resurgent medical concerns about its scientific efficacy. Such a disparity between the incorporation of these two CAM therapies within orthodox medicine necessitates a look at the responses of the Portuguese medical profession to CAM at the institutional level. More specifically, this chapter attempts to answer the following research question: To

what extent has CAM been incorporated into the medical establishment in Portugal? This chapter is divided into two main sections: (1) the first one addresses the dynamics of the institutional medical recognition of CAM over time, by presenting acupuncture and homeopathy as two case studies; (2) the second one examines the views of medical acupuncturist and medical homeopathic leaders on the rhetoric used by the medical establishment for legitimising acupuncture but not homeopathy in Portugal. Attention will be paid to an institutional level analysis of the data. Medical acupuncturists or/and medical homeopaths (n=11) who occupy a leading position in encouraging the institutional medical recognition of CAM in the country, are the focus of analysis.

6.2. The Historical Context of Acupuncture and Homeopathy within Portuguese Healthcare

The traditional existence of a powerful medical profession in Portugal is crucial to understanding the dynamics around the medical recognition of CAM in the country. Diogo (2004), for instance, pointed to the fact that the creation of the National Health System in 1979, after the political reform of 1974, created a high demand for medical doctors who were seen as a valuable and scarce resource. As a result, incentives were created to increase the number of these professionals through the delegation of power and flexibility given to medical doctors to manage their professional careers. State control over medicine's licensure has traditionally also been of significance in the country (Carapinheiro and Rodrigues, 1998). As Carapinheiro and Rodrigues (1998) state, the Portuguese Medical Council (PMC) was founded in 1938 under a corporate and authoritarian State that aimed to have control over medical credentialism in the country. The PMC is a corporate association for which membership is compulsory for medical doctors (Oliveira et al., 2005) and which has the ethical and disciplinary power to censure and punish medical doctors (Barros and Simões, 2007). Medical doctors are not permitted to call themselves homeopaths, as according to the *Portuguese Medical Council's Code of Ethics* (2008), titles other than medical doctor are prohibited for membership and the PMC can exercise disciplinary actions such as banning an individual from practising medicine.

Despite the PMC's traditional rejection of CAM in general, there has always been medical enthusiasm for one or another form of CAM in Portugal at the level of the clinical practice. Mira (1947), in his book *The History of Portuguese Medicine*, gives various examples of Portuguese medical doctors who in the 18th century were

committed to unorthodox practices, including the manufacture of their own remedies and the incorporation of folk theories about health. Ventura (2007), a popular naturopath within the Portuguese CAM circle, claims that before the revival of CAM in the 1980s, naturopaths – who Borgerson (2005) aptly calls the GPs of CAM – such as Índiveri Colucci and medical doctors such as Amílcar de Sousa or Adriano de Oliveira, were among the few supporters of naturopathy, today being considered as the leaders of CAM revival in Portugal. According to Ventura (2007), the efforts of these personalities to institutionalise naturopathy in the country failed due to the existence of a very conservative society at the time, ruled by a fascist regime until 1974.

In the last ten years, however, the institutional medical interest in acupuncture has acquired an ever-growing impulse. Although the medical practice of acupuncture in Portugal is seen to have been in use at least since the 1980s, it was only in 2001 that medical doctors acquired the legal right to practise this therapy. Interestingly, in parallel with the political contest over CAM regulation, which lasted from 1999 up to the present, on the 19th August 2001 the *Portuguese Medical Society of Acupuncture* (*Sociedade Portuguesa Médica de Acupunctura* – S.P.M.A.) was set up and tasked with establishing criteria to determine competency in ‘medical acupuncture’. Nine months later, on the 14th May 2002, the PMC approved and applied these criteria to medical doctors. In practice, this move towards the institutional acceptance of acupuncture³² led to the creation of a postgraduate course in ‘medical acupuncture’ accredited by the PMC in order to:

... adequately train a higher number of medical doctors to use this *therapeutic technique, thus integrating* acupuncture in their clinical practice, and *basing this practice on clinical and scientific evidence*. (Faculdade de Ciências Médicas da Universidade de Lisboa – FCMUL – 2009, my emphasis).

The first academic institution to introduce the postgraduate course in ‘medical acupuncture’ was the *Abel Salazar’s Biomedical Science Institute* (ICBAS) in Porto. This postgraduate course has since spread around the country and is now being taught at the Faculty of Medicine in the University of Coimbra and the Faculty of Medical Sciences in the New University of Lisbon³³. In 2009, according to the Portuguese press,

³² Although acupuncture was included in an earlier codification of medical acts, as published by the Portuguese Medical Council. Available at: <http://www.nortemedico.pt/textos/?imr=3&imc=6n423n>

³³ Portuguese Medical Society of Acupuncture (S.P.M.A.) website. Available at: http://www.spma.pt/?page_id=91 (Accessed on the 3th April 2012)

at least 63 medical doctors had acquired the S.P.M.A.'s accreditation in medical acupuncture in Portugal (Gomes, 2009). Some aspects of this course are worth mentioning in more detail. In the first place, the course aims specifically to promote the use of 'contemporary medical acupuncture', defined as '... a neuromodulation technique, through the insertion of metallic needles through nerve paths' (FCMUL, 2009), and based on scientific research. Secondly, the entire course is delivered only to medical doctors, excluding other healthcare professionals.

It has been suggested here that significant changes have been made to the status of acupuncture within the Portuguese medical establishment over the last decade. For, from a therapy practised in the shadows of legal medical practice and from its roots in ancient Chinese theory, acupuncture has turned into a recognised biomedical technique with increasing scientific evidence and has been incorporated into clinical medical practice. Furthermore, 'medical acupuncture', as integrated into the national healthcare system, can only be practised by medical doctors in healthcare centres and in hospital settings, although this usage is essentially limited to the area of pain. This change in the medical establishment's disposition towards CAM and the move towards the incorporation of acupuncture therefore could be interpreted as a countervailing move of the medical profession. For, in an effort to prevent the possible consequences of the recent predisposition of Portuguese State to nurture CAM in the healthcare market, the medical establishment, during the political contest of CAM regulation in the country, strategically enacted regulation which incorporated acupuncture within the biomedical practice and gave medical doctors the privilege of being the only professionals legally practising acupuncture within mainstream healthcare in the country.

Homeopathy has not shared the same enhanced status as acupuncture within the PMC. Although homeopathy has traditionally been embraced by a number of medical doctors in the country, and although medical enthusiasm for this therapy can be traced further back in time than for acupuncture, homeopathy essentially remains a rejected and attacked therapy by the PMC, which continues to regard it as 'quackery'. Authors like Mira (1947) and Araújo (2005), for instance, have documented that medical interest in homeopathy in Portugal goes back to the 19th century. Araújo (2005) has shown that medical attempts to legalise and accredit homeopathy go back to the second half of the 19th century, with the support of sympathetic personalities from the Portuguese aristocracy and from the political, artistic and medical spheres of the time. Many stories

abound about these personalities' successful personal use of homeopathy. Moreover, a small fraction of medical doctors have actively worked for the professionalisation of homeopathy in Portugal by setting up homeopathic clinics, professional associations and journals, although these appear to have been extinguished over time. Interestingly, homeopathy was even taught informally in some medical schools by academics who were supporters of this therapy (Araújo, 2005). Mira (1947) has showed how some 19th century Portuguese medical doctors 'seduced' by homeopathy attempted to set up homeopathic *boticas* (an earlier form of pharmacy) and to incorporate homeopathic treatments in public hospitals. The failure of homeopathy's attempts to gain legitimacy in the country can be attributed to the medical resistance of the homeopathic ideology, which was seen as 'fallacious' and 'sinister', according to a report by the *Medical School of Surgery of Lisbon* at the time (Mira, 1947). This institutional medical position towards homeopathy from two centuries ago does not seem to have changed over time, as homeopathy continues to be seen as an alien and 'Palaeolithic' therapy, as described in the PMC's Report on the two CAM Bill projects presented to the Portuguese parliament in 1999 (SRNOM, 2001; 1999a).

The tradition of medical homeopathic associations in Portugal is another significant phenomenon. Araújo (1995) shows, for instance, how the turn of the 20th century was marked by the setting up of many homeopathic associations by medical doctors and pharmacists, which gradually disappeared over time. At present, there are at least two dominant medical associations of homeopathy in the country: the *Homeopathic Society of Portugal* (*Sociedade Homeopática de Portugal* – SHP), which was founded in 2003 by a small group of medical doctors and pharmacists who defined homeopathy as a 'medical approach'³⁴; and the *Portuguese Society of Homeopathy* (*Sociedade Portuguesa de Homeopatia* – SPH), about which very little information has been disclosed or provided. These two associations have also set up courses in homeopathy. The extent to which these courses are designed either for medical doctors and other healthcare professionals or for people without previous formal healthcare training remains ambiguous.

In the past, there was also a strong relationship between medical doctors and pharmacists in Portugal who were both committed to homeopathy, with the setting up of

³⁴ Sociedade Homeopática de Portugal (SHP; *Homeopathic Society of Portugal*) website. Available at: <http://www.homeopatiaportugal.org/paginas/faqs.php> (Accessed on the 5th December 2009).

many homeopathic/allopathic pharmacies over time, some of which still remain open today (Araújo, 1995). The medical doctors used to manufacture their own remedies and later requested their remedies to be prepared from a *boticário*, a dispensing chemist or an earlier version of the modern Portuguese pharmacist (Mendes and Braga, 2001). In the same way as medical doctors fought to legitimate homeopathy in relation to their institutional body, pharmacists who were interested in homeopathy in the past used to fight against the Pharmaceutical Council, which was against this therapy as it did not ‘dignify’ the status of pharmacological science (Araújo, 1995). Ironically, the manufacture, commercialisation and utilisation of homeopathic remedies for human use have been legislated for by the Portuguese government through the Decree-Bill n° 94/95 from 9th May 1995 (and later replaced by the Decree-Bill n° 176/2006 from 30th August 2006; ARP, 1995; 2006). This Decree addressed the increasing use of homeopathic remedies in the country with advisory input from the Medical and Pharmaceutical Councils with regard to the new national directives on the manufacture, commercialisation, labelling and distribution of homeopathic remedies, a responsibility which was placed under the jurisdiction of the *National Authority on Pharmacy and Medicinal Products* (Infarmed – *Autoridade Nacional do Medicamento e dos Produtos de Saúde I.P.*).

The power given to the Medical and the Pharmaceutical Councils by the State to intervene in the decisions surrounding homeopathic remedies is thus important. The former Decree-Bill n° 94/95 distinguishes between two sorts of homeopathic remedies: ‘homeopathic drugs’ (*medicamentos homeopáticos*), which are defined as having a curative and preventative status and to which directives applicable to conventional drugs are applied; and ‘homeopathic pharmaceutical products’ (*produtos farmacêuticos homeopáticos*), relabelled later as ‘homeopathic drugs within a simplified regimen’ (*medicamentos homeopáticos sujeitos a registo simplificado*) by the Decree-Bill n.º 176/2006. Interestingly, in order to acquire this latter status, homeopathic drugs must meet specific criteria, such as being clearly labelled as ‘homeopathic drugs without approved therapeutic indications’.

Therefore, at present acupuncture and homeopathy in Portuguese society appear to occupy contrasting statuses within the medical establishment. The former has clearly been co-opted or absorbed by biomedicine, while the latter is still banned by the medical establishment, despite its incorporation at the level of the clinical practice. This

dialectic leads us to an exploration of the rhetorical strategies used by the PMC to legitimise acupuncture but not homeopathy. In the following section, the views of medical acupuncturists and medical homeopaths who have had a leading role in the medical recognition of CAM in the country on the differential incorporation of acupuncture and homeopathy into the medical establishment, will be examined.

6.3. Factors Influencing the Differential Status of Acupuncture and Homeopathy within the Medical Establishment: Medical Insiders' Views

Lack of Scientific Evidence or Medical Prejudice?

The rhetoric regarding the lack of scientific evidence of CAM pervaded all the leaders' accounts. Interestingly, mainly amongst medical acupuncturist leaders, the idea that homeopathy lacks scientific evidence was seen as its main legitimacy problem. For instance, one accredited medical acupuncturist who represented the *Portuguese Medical Society of Acupuncture* (S.P.M.A.), compared acupuncture and homeopathy in the following way:

As far as I know the weak thing about homeopathy is the lack of scientific evidence. So, in acupuncture we can *scientifically show* that there are situations where it [acupuncture] works or doesn't work... in randomised trials, by comparing groups ... But in homeopathy as far as I know we cannot reach an explanation for the way it works and why it works. (I25: MA, my emphasis)

This statement illustrates a very institutional viewpoint coming from a participant with a key role in the accreditation of 'medical acupuncture' in the country. It is of interest to note that this respondent demarcated acupuncture from homeopathy by using the scientific validation argument. Such demarcation indicates the existence of CAM stratification within biomedicine based on scientific criteria. Although this medical acupuncturist supported homeopathy by saying that it often works, he also emphasised its experiential rather than scientific levels of evidence and claimed that it can not be scientifically validated in the same way that acupuncture has been.

Conversely, among the medical homeopathic leaders, the argument about homeopathy's lack of scientific evidence base was challenged as being absurd. The following non-accredited medical acupuncturist who was committed to homeopathy and who was a

representative from the *Portuguese Society of Homeopathy* (SPH), when asked why the PMC still rejects homeopathy, sarcastically pointed out:

Well, why doesn't the Medical Council accept it [homeopathy]? It would be better to ask the Council. But what they [the PMC] have publicly said is that it [homeopathy] doesn't have a scientific basis. And according to them [the PMC] [homeopathy] doesn't have a scientific basis because there aren't enough clinical studies and research to give credibility or an explanation to the way homeopathic remedies work. I think this is not the fact, as there is already a huge amount of scientific research published in renowned international journals by researchers ... by either medical doctors or scientists from different fields who in fact document the use of homeopathic remedies with specific clinical results. (I33: MA, MH)

In the same way, other leaders have claimed that the PMC's argument about homeopathy's lack of scientific evidence base is disingenuous and has been used as a convenient explanation for rejecting this therapy, as there has been considerable research done on homeopathy with clear results of its success. One of the leaders, an accredited medical acupuncturist who was also committed to homeopathy and who was a representative of the *Homeopathic Society of Portugal* (SHP) declared that homeopathy, and not acupuncture, should have been the first CAM therapy to be recognised by the PMC because it was based on wider research than the latter:

It should have been the other way round. Because we have research on homeopathy and much less research on acupuncture. (I30: MA, MH)

The idea encapsulated in the long conversation below with an accredited medical acupuncturist, a representative from the S.P.M.A. and from the Infarmed, who was committed to homeopathy, is representative of most of the leaders' perspectives on the current status of homeopathy within the Portuguese medical establishment:

JA: What do you think about the future of homeopathy within medicine?

I: It's difficult. It's very difficult. It's difficult because there are big pressures, much prejudice in relation to homeopathy.

JA: By the medical doctors?

I: Yeah, from a certain sector of conventional medicine.

JA: Do you think it's just prejudice?

I: Yes, there is much prejudice, for sure. Much, much prejudice. And the rejection of certain evidence.

JA: You mean scientific evidence? Is there scientific evidence to support homeopathy?

I: Yes, it has. It has scientific evidence, not so much as acupuncture, for instance, but it has enough scientific evidence to be considered as a valid therapy for many conditions.

JA: The question about dilution under the Avogadro's number³⁵ ...

I: Yeah, it's a complicated question because if they [the PMC] don't accept that there is in fact something there, it will be difficult to move forward.

JA: And is it really proven that information remains there [in the water] in fact?

I: From the point of view of Physics, yes, it's already proven. But just from a Physics stance, at the moment ...

JA: And do you think that sooner or later it will be ...

I: I don't know, really. ... Sometimes the world is so cruel, right, the evolution of things is a bit cruel and sometimes what benefits it's not always the best thing, right. We've seen that in human history, right. Sometimes only in the future, right. Copernicus also had troubles ... Galileo, etc.

JA: Do you think that the Medical Council ...

I: That's a group. A group. It's not only a person. It's an influential group. Because then ... look ... there are many people who could risk their position if they showed interest in something like this [homeopathy]. They would risk their position a lot. If they happen to have an important position. So, it's better to be careful. And I can understand that. (I23: MA, MH)

What is being claimed by this leader is that while homeopathy has been increasingly tested by scientific research, often with good results for certain healthcare conditions, orthodox medicine is still resistant to it, motivated by prejudice. This leader referred to 'resistance to innovation' (Jones, 2004) and compared homeopathy to some other 'heresies' which were later incorporated into mainstream science. Furthermore, this leader emphasised that whilst the 'medical heretics' (Wope, 1990) within the Council could embrace homeopathy, this would be at great risk. The underlying premise of this quotation seems to undermine the medical argument of the scientific implausibility of homeopathy by instead highlighting the role of power, status and lobbying relationships within the PMC which have served to undermine the legitimacy of this therapy. This respondent made it very clear that in their view, without the influential PMC's acceptance of homeopathy's rationale, it will be impossible for this therapy to move

³⁵ The calculated number of atoms or molecules in a substance.

from the margins.

The prejudice and ‘resistance to innovation’ attributed to the Portuguese medical elite could be regarded as a manifestation of the traditional power of the PMC in Portugal, in particular the ethical and disciplinary power this institution has over its members. Although banned by the PMC, homeopathy continues to be practised by a few medical doctors in the country. The concern about divulging their commitment to a ‘forbidden therapy’ was a concern that many medical homeopathic leaders raised. Medical leaders who practise homeopathy often seemed to use strategies to protect themselves from the Council, as the following example from a medical homeopath, who was a representative from one of the medical associations of homeopathy in the country, illustrates:

I usually say I’m the chairman of the [name of the institution]. I cannot say I’m a homeopath because a friend of mine was penalised as it [homeopathy] doesn’t exist neither as a speciality nor as a competency in our country and so medical doctors cannot claim a title that doesn’t exist. ... So, I usually say I’m the chairman. ‘Am I a homeopath?’ ‘No’. (I27: MA, MH)

Despite the institutional barriers to developing and delivering formal training in medical homeopathy, the medical homeopathic leaders in this study acquired homeopathic training either inside or outside the country. Although the nature of some training courses remains ambiguous, some leaders disclosed the involvement of pharmaceutical laboratories in their training:

JA: Was it in Portugal, the course you attended?

I: Yes. It was in Portugal but it was a French laboratory, Boiron, which gave training here in the country to those who were interested [in homeopathy]. Actually there were very few people interested [in homeopathy]. We were in total around 20 medical doctors. This was about 20 years ago. Less than 20 years.

JA: Was it only for medical doctors?

I: Medical doctors and pharmacists. Only medical doctors and pharmacists. And was delivered by medical doctors. (I29: MH)

Although the above quotation is illustrative of the way in which these leaders used to acquire credentialism in homeopathy during the 1990s, this situation does not appear to have changed. The most common ways to acquire credentialism in homeopathy have been to seek training abroad and to attend informal and private courses organised by

pharmaceutical laboratories and medical homeopathic associations in Portugal. The involvement of the pharmaceutical industry in homeopathic training is thus a clear sign of support of this therapy. There was also anecdotal evidence of leaders drawing on the expertise of lay homeopaths without actually associating themselves with lay homeopathic groups.

The marginal place that homeopathy currently occupies in the medical establishment and thus at an institutional level is reminiscent of the place occupied by acupuncture during the 1980s, before its incorporation into the medical establishment. One accredited medical acupuncturist who was committed to homeopathy and who was a representative from the S.P.M.A. put it very clearly when talking about the early medical promotion of acupuncture in the country:

By that time, let's say... in the 80's, there were courses for medical doctors... in Portugal... but they were private courses, you see? ... The courses were run by those who had already started learning acupuncture and thought it would be interesting to share [that learning] with other colleagues who couldn't leave the country... there were [courses] in Porto even in the ICBAS [Abel Salazar's Biomedical Science Institute] premises... you see, it wasn't a course from the university but they, let's say, lent the premises and that's how the medical promotion [in acupuncture] started. (I23: MA, MH)

Further reasons related to acupuncture and homeopathy's idiosyncrasies, and to the differences in power and economic interests between these therapies and the medical orthodoxy and the pharmaceutical industry were also highlighted by some leaders as being significant in explaining the differential status of these therapies within the PMC. This issue will be now considered in further detail in the next section.

Idiosyncrasies of Acupuncture and Homeopathy

The medical prejudice and 'resistance to innovation' in the case of homeopathy was often associated with this therapy's idiosyncrasies. The differential incorporation of acupuncture and homeopathy were rendered particularly distinctive when definitions of these two therapies and their comparisons with biomedical ideology were disclosed by the leaders. It is therefore pertinent to mention briefly the underlying purposes for acupuncture and homeopathy's rationale.

Acupuncture is an ancient therapeutic technique of Chinese medicine which consists of

the insertion of fine needles into specific acupoints in the body (Gwei-Djen and Needham, 1980). In its classical form, it is a main component of Traditional Chinese Medicine and is informed by the Chinese theory of treating *qi* (energy) flow imbalances to restoring health. Acupuncture is thus an ancient needle therapy and is therefore a drugless technique imported from the East. Homeopathy, in turn, presents as a nineteenth-century non-allopathic medicinal system (Fulder, 1996) based on three main principles: ‘the simile’, or the idea that treatment should be based on drug-symptom similarity (Nicholls, 1988); the principle of the minimum dose, in contrast with the biomedical perspective that accepts that doses can be increased by combining different drugs (Nicholls, 1988); and the principle of high dilution or potency, i.e. the idea that remedies can retain their power after being diluted and agitated (or shaken) beyond Avogadro’s number, the point at which it is scientifically believed that no more molecules of the original substance remain (Degele, 2005). In short, homeopathy presents itself as a Western medicinal system with an ideology of healing which is predominantly contradictory to the biomedical one³⁶, yet which also lays claim to the use of medicinal substances with a pharmacological or chemical influence (Nicholls, 1988). Nevertheless, the homeopathic pharmacopeia is considered very distinctive and antagonistic to the biomedical one, due to the principles outlined above.

From the perspective of some leaders, a main focus of conflict between homeopathy and the medical establishment was the presence of an esoteric homeopathic theory underlying healing practices. Homeopathy has not yet acquired a biomedical interpretation and is therefore still seen as quackery and rejected by the PMC. For instance, homeopathy’s use of substances without proven efficacy was often emphasised as an example of this. As an accredited medical acupuncturist leader who used to integrate acupuncture in her NHS practice put it:

Look, acupuncture is *only a technique* that uses needles without chemicals, without remedies, by neural stimulation, while homeopathy uses remedies which perhaps we still need to know where the benefit starts and where the non benefit ends. That’s the difference [between acupuncture and homeopathy], I believe. (I26: MA, my emphasis)

This last statement clearly places acupuncture in opposition to homeopathy in relation to their idiosyncrasies. Acupuncture is seen as a technique where the key instrument of

³⁶ Although biomedicine often uses treatments based on the simile principle such as vaccination (Nicholls 1988).

healing is a needle and not drugs or some other internal remedy. Although this quotation emphasises the biomedical co-option of acupuncture by reducing it to a biomedical technique through defining it as a neural stimulation, it still points to its ancient roots as a drugless and extraneous technique. Indeed, adopting a social closure theory approach, it could be argued that the drugless nature of acupuncture is not seen as a threat to the hegemony of the biomedical ideology in fields such as pharmacology or pharmaceuticals, thus making it amendable to biomedicine. Homeopathy, on the other hand, is related to the use of remedies which have unpredictable results. Such a view is reflective of the esoteric nature of homeopathic theory that has traditionally been attributed to these remedies by the medical establishment. Furthermore, by stating what acupuncture is not, the respondent attempted to address a pharmacological influence on homeopathy, which within a framework of ‘countervailing powers’, is indicative of the potential power imbalance that this therapy might cause in biomedicine’s relationship with the pharmaceutical industry.

Indeed, some other leaders showed concern about the ongoing dynamics between homeopathy, medical orthodoxy and the pharmaceutical industry worldwide. In this respect, an accredited medical acupuncturist who was a representative from the S.P.M.A., disclosed that the pharmaceutical nature of homeopathy may challenge the relationship between medical orthodoxy and the pharmaceutical industry and so may be one of the reasons why it has not been accepted by the PMC:

Homeopathy gets into another area which is the pharmaceutical one, the pharmaceutical industry. And there will be big economic interests too ... but I’m not sure if it’s only that. Because in France, for instance, homeopathy is widely promoted and there are [homeopathic] pharmacies and so on ... I think that has to do a bit with both the issues. With commercial aspects ... but within the Medical Council ... I think it’s more the lack of scientific evidence. Try and ask my colleagues ‘so, how does homeopathy work?’ Do they really know? I think they don’t understand it very well. (I25: MA)

It is interesting to note that the comments pertaining to the medical profession’s interests and to its relationship with the pharmaceutical industry arose from ‘medical insiders’, that is, conventional medical doctors. This leader claimed that the economic and commercial interests of the pharmaceutical industry in relation to homeopathy, which encourage the potential marketing of homeopathic remedies and research funding in homeopathy, may capitalise on homeopathy and may therefore initially contribute to the institutional medical rejection of this therapy. This leader referred to the example of

France, a major producer and consumer of CAM remedies (Ramsey, 1999) which are dispensed in almost all pharmacies (House of Commons, 2010). Nevertheless, the right to practise CAM in France is monopolised by medical insiders like medical doctors and forbidden to medical outsiders (Ramsey, 1999) such as lay acupuncturists or lay homeopaths.

In Portugal, the current consumption and supply of CAM remedies are far from being as significant as they have been in France. Lay confidence and trust in medical doctors and in orthodox healthcare in Portugal remains at a high level (Cabral et al., 2002). Furthermore, lay autonomy towards ‘medical power’ in Portugal is one of the lowest in Europe (Alcântara and Cabral, 2007). Therefore, lay perceptions of homeopathy are still highly influenced by institutional medical rhetoric around this therapy. In addition to this, homeopathy has neither achieved statutory regulation nor acquired institutional medical recognition. Consequently, homeopathic remedies have not merited significant lay interest and have therefore not been profitable. However, the CAM Bill 45/2003, if implemented, offers an attractive scenario for both lay homeopaths and the pharmaceutical industry in the country. While lay homeopaths may become regulated and consequently provide homeopathic treatments and prescribe homeopathic remedies³⁷, the pharmaceutical industry may capitalise on such remedies and has a stake in the potential emergence of lay interest in homeopathy. However, claims about the strong link between the pharmaceutical industry and the medical establishment in Portugal through the pharmaceutical industry’s commissioning or funding of biomedical research and education were also highlighted by a few leaders in this research. As the following accredited medical acupuncturist, a representative from the *Homeopathic Society of Portugal* and also a medical homeopath disclosed:

Because there are lobbying groups within the Medical Council. As I said, the laboratories are the ones who control training in higher education. They financially support everything. The research carried out in the hospitals. The laboratories, the multinationals ... after the military-industrial complex, the pharmaceutical industry [is the most powerful one]. (I27: MA, MH)

To summarise, the rhetoric of medical prejudice and resistance to innovation of the Portuguese Medical Council prevailed amongst most of the medical acupuncturists and

³⁷ In ‘Homeopatia: Proposta Completa’, the proposal submitted to the Ministry of Health by representatives of homeopathy from the consultative Commission tasked with the establishment of the criteria for CAM statutory regulation in the country.

medical homeopathic leaders in this research. This is understandable within a context of traditional medical corporatism and conservatism in the country, where the Medical Council has had authority, delegated by the State, to regulate medical practice. However, as shown in the preceding section, this is not sufficient to explain the differential incorporation of acupuncture and homeopathy by the medical profession. The medical acupuncturists and medical homeopathic leaders in this study also raised differences in the intrinsic nature of acupuncture and homeopathy. For, while the former was seen as a ‘drugless technique’, the latter was compared to biomedicine due to the use of substances with a pharmacological or chemical basis. This last aspect, in turn, may undermine biomedicine’s longstanding relationship with the pharmaceutical industry, as the latter has aligned with CAM interests by showing growing interest in homeopathic pharmacopeia and by fostering training and the homeopathic market. We are now in a position to draw some conclusions.

6.4. Discussion

In this chapter the response of the medical profession to CAM at an institutional level has been explored. The following research question has been addressed: To what extent has CAM been incorporated into the medical establishment in Portugal? It has been shown that the PMC’s interest in CAM has changed. For example, although grassroots medical interest in acupuncture appeared to start increasing from the 1980s, it was only at the turn of the 21st century that the PMC shifted its perspective from a position of rejection to one of ‘tacit’ incorporation (Saks, 1995a). The incorporation of acupuncture involved the creation of the *Portuguese Medical Society of Acupuncture* (S.P.M.A.) and of a medical competency in acupuncture. It seems therefore that in relation to acupuncture, Portugal has followed a similar path to other Western Countries. This therapy has been co-opted by biomedicine and absorbed by biomedical theory. Furthermore, it has been incorporated into the national healthcare system, is practised by medical doctors with competency in ‘medical acupuncture’ and is limited to specific medical conditions, such as those involving pain³⁸. For all these changes, acupuncture has acquired a privileged status within the Portuguese medical establishment.

The findings outlined here suggest that the Portuguese incorporationist scenario

³⁸ Although recent claims by the S.P.M.A. to extend the use of medical acupuncture within the healthcare system to branches of medicine such as general practice, obstetrics and gynaecology, have been reported. See the S.P.M.A. website <http://www.spma.pt/> (Accessed on the 30th November 2010)

pertaining to acupuncture has not been observed in the institutional biomedical reaction to homeopathy. Although there is a small faction of medical doctors in the country who have been committed to homeopathy for a long time and who have fought for its medical recognition, the PMC still prohibits and attacks its practice. Among some medical homeopathic leaders in this study, for instance, there was a common concern about disclosing their commitment to this therapy, which may reflect the disciplinary power of the PMC in the country and the impact of this on professional rhetoric. So, in contrast to acupuncture, homeopathy has neither been incorporated into, nor enhanced its legitimacy within the medical establishment. Recalling Van Haselen (2005), the debate surrounding homeopathy within the Portuguese medical establishment is still more about 'should homeopathy be present at all' than about its possible routes of incorporation into the formal healthcare system, as has happened in some Western countries. Thus, it can be argued that in the case of Portugal, it seems more appropriate to talk about 'differential incorporation' rather than just incorporation of CAM into the medical establishment, as the former concept acknowledges diversity within CAM as well as allows for different relationships between the medical profession and the different CAM therapies.

The findings outlined in this chapter point to the view that the biomedical rhetoric about homeopathy's lack of scientific evidence has been interpreted by most leaders as merely a convenient explanation for the medical establishment's rejection of homeopathy. Prejudice and 'resistance to innovation' (Jones, 2004), such as resistance to homeopathic ideology, were essentially seen as the PMC's responses to homeopathy. Interestingly, medical interest in homeopathy in the country goes further back than that in acupuncture. Homeopathy in Portugal dates back to the 19th century, at a time when medicine itself began to undergo a process of professionalisation, and when the balance between science and mysticism was still being negotiated (Araújo, 2005). At that time, a small fraction of medical doctors actively advocated the professionalisation of homeopathy in Portugal, in addition to which there were a few attempts to legalise and accredit this therapy in the country. It thus appears that the practice of homeopathy within the medical circle in Portugal has been ghettoised over time, as it never gained the support of the conservative medical establishment and was unable to fight successfully against the biomedical ideology of healthcare that has been dominant in Portugal.

Ironically, the manufacture and commercialisation of a number of homeopathic remedies for human use have been allowed in the country since 1995, although some remedies require a disclosure that they are without proven therapeutic outcomes. This last aspect raises a very interesting question: if it is biomedically perceived that some homeopathic remedies do not have therapeutic indications, and if homeopathy's lack of scientific evidence of effectiveness still appears to be of major concern to the medical orthodoxy, on what basis are such remedies being sold in the healthcare market? In this respect, Law (2006), for instance, suggests that medical doctors are incapable of applying the brakes to the pharmaceutical industry's need to prosper and to expand its market. This means that focusing solely on the rhetoric of a lack of scientific evidence of CAM or on medical prejudice and 'resistance to innovation' as reasons for the PMC's rejection of homeopathy can obscure some of the commercial and economic factors that may also be responsible for, or contribute to, changing the position accorded to homeopathy by the PMC.

Acupuncture, it has been argued here, has acquired higher status within the Portuguese medical orthodoxy in part because of its lack of reliance on drugs, which does not overtly threaten either the pharmaceutical nature of biomedicine or the latter alliance with such actors as the pharmaceutical industry³⁹. However, it could possibly threaten the pharmaceutical industry itself, as it may provide a 'more socially acceptable, tolerable and inexpensive [treatment] than the more conventional drugs manufactured by the pharmaceutical industry' (Rathbone and Xia, 2009). It was disclosed by the medical leaders in this research that homeopathy has a pharmaceutical influence, in the sense that some of the homeopathic remedies can have a biochemical basis. As was alluded to earlier, until very recently the pharmaceutical industry had underestimated the homeopathic market. Now, in line with its profit and patient oriented ideology (Law, 2006), this actor has acquired increasing interest in homeopathy, as the latter has attained greater social recognition, and subsequently stimulated drugs sales. This could lead to an imbalance in power between the pharmaceutical industry and the medical profession and could therefore represent a threat to the hegemony of the biomedical ideology within the pharmaceutical industry.

Although a detailed analysis of the recent incursion of the pharmaceutical industry into

³⁹ Although its cousin mesopuncture, which deals with the injection of a product into acupuncture points, may pose a threat to such an alliance.

the homeopathic market is beyond the scope of this chapter, further speculation about the future scenario of homeopathy within the Portuguese healthcare system can be presented. Firstly, how far will the pharmaceutical interest in homeopathy go in the Portuguese context? Consequently, to what extent can the pharmaceutical industry's emerging interest in homeopathy change its balance of power with the medical profession? Finally, to what extent can the pharmaceutical industry pressurise the medical profession to change its position towards homeopathy? As Light (1995:33) has emphasised, the implication of countervailing games 'is that each party has legitimate goals and values which are not easy to fit with the others and which can lead to serious imbalances in their own right'. As a profit-oriented institution, the pharmaceutical industry has been exploring and promoting homeopathy in the healthcare market; as a very powerful and influential institution which has a strong relationship with the public, it may contribute to enhancing homeopathy's legitimacy and scientific credibility in future.

Furthermore, if the emerging alliance of the pharmaceutical industry with homeopathy was to result in greater scientific evidence being established for the latter, for example through the commissioning or funding of homeopathic research, then the medical orthodoxy might be expected to counteract this move through ensuring that it maintains its dominant status and power within the healthcare system. One such strategy might be to open its doors to this therapy. In the case of Portugal, where the rhetoric about the lack of scientific evidence of homeopathy and medical prejudice towards this therapy have sharply characterised the institutional medical position, the emerging interest of the pharmaceutical industry in homeopathy and the potential increase in its scientific evidence base could lead to a shift in this therapy's status within the medical establishment. This could mean a change from the long-standing institutional medical position of rejection to one of 'enhanced legitimacy' or even to the incorporation of homeopathy in the medical establishment in the country. This would render Portugal closer to Western countries such as France where homeopathy has been amenable to biomedicine. However, were this scenario to occur and homeopathy were to acquire greater medical legitimacy, this would not necessarily be a direct consequence of its increasing scientific evidence base (the reason for its current rejection), but rather as a result of the wider professional and socioeconomic interests that have contributed to shaping healthcare more generally.

Theoretical literature and empirical research on the pharmaceutical industry as a countervailing power in relation to mainstream healthcare has been rare. Mechanic (1991) alerted us to the growth of countervailing power in healthcare despite focusing more on third-party insurance companies. Hartley (2002) illustrated how the relationship between different countervailing powers has formed a system of alignments challenging biomedical dominance, although she did not pay too much attention to the role of the pharmaceutical industry. Busfield (2010:940), however, in her analysis of the key forces contribution to the expansion in medicine use, shows how the pharmaceutical industry, ‘... through its pursuit of profits and skilful use of marketing, its control of science, and its disease mongering, has been a major driving force in the current [medicine] expansion’. The present chapter aims thus to contribute to the framework of countervailing powers by presenting the pharmaceutical industry as a driving force in the current CAM regulation and in the current expansion of camisation.

The purpose of this chapter has been to examine the medical establishment’s response to CAM in Portugal. It was suggested that there has been a differential incorporation of CAM by the medical establishment. Such incorporation, in turn, can be interpreted as a result or a consequence of CAM practitioners’ attempts to encroach into mainstream healthcare. Furthermore, the incorporation of CAM by medical doctors appears to have involved accepting the process of camisation but under the circumstance of having control over its terms and conditions. That is, incorporating CAM means setting the rules under which camisation should operate within mainstream healthcare system. We should now turn to Chapter Seven to address the response of the medical profession to CAM at the micro level, i.e. at the level of orthodox medical doctors not committed to CAM, and their responses to CAM practitioners’ attempts to encroach on mainstream healthcare.

CHAPTER SEVEN

THE SUBORDINATION OF CAM

BY ORTHODOX MEDICAL DOCTORS

7.1. Introduction

In Chapter Six the differential response of the medical establishment towards acupuncture and homeopathy in Portugal was analysed and it was revealed that the medical establishment has incorporated acupuncture but not homeopathy. Therefore, CAM has partially enhanced its status within the medical establishment in Portugal. It was suggested that the incorporation of CAM by the medical profession is a strategy of the latter to gain control over camisation, or the process of promoting CAM solutions and treatments to human problems. In this chapter the recent response of the medical profession to CAM and to camisation will be now analysed at the level of the individual practice. The professional responses of orthodox medical doctors not committed to CAM will therefore be the focus of the following analysis.

Chapter Two showed that a neo-Weberian approach to the professions is often adopted for analysing the medical profession's relationship with CAM. These closure theorists have suggested that the medical profession has traditionally employed exclusionary and demarcationary strategies to differentiate themselves in status and power from other occupations, thus acting as a dominant occupational group (Murphy, 1988; Parkin, 1979; Witz 1990, 1992). Some of these exclusionary and demarcationary strategies have been already identified in the literature. With regard to CAM, claims about the lack of scientific knowledge and credentialism have been analysed as the main exclusionary strategies (Kelner et al., 2004). By suggesting that CAM does not have scientific validity and CAM practitioners do not hold credentials, specialised training, professional ethics and group cohesion, and are thus unable to deal with healthcare issues, orthodox medicine has also engaged in a 'boundary-work' (Gieryn, 1983; Gieryn et al., 1985) by demarcating its 'scientific' and 'structured' transmission of knowledge from the 'empirical' and 'charismatic' transmission of knowledge (Cant, 1996) of CAM. Through exclusion, demarcation and boundary-work, the medical profession has exercised power in a downward direction towards CAM and CAM practitioners.

Previous studies which have focused on the attitudes of the medical profession towards CAM at the level of individual practice (Hirschhorn and Bourgeault, 2005:167), have

suggested that medical doctors usually engage in ‘professional role-taking’, ‘which takes place at the intersection of individual disposition [towards CAM] and professional and structural demands [concerning CAM use]’. In other words, Hirschhorn and Bourgeault (2005) have proposed that medical doctors tend to adopt more institutionalised views in their rhetoric about CAM. It is thus important to examine at length the views of orthodox medical doctors on CAM in Portugal. This chapter attempts to answer the following overarching research question: How have orthodox medical doctors responded collectively to CAM practitioners’ attempts to influence healthcare in Portugal? The findings presented in this chapter draw on the professional views of medical doctors uncommitted to CAM, particularly five general practitioners (GPs) and five surgeons (in total n=10).

7.2. The Professional Responses of Orthodox Medical Doctors to CAM: General Practitioners and Surgeons

The research conducted for this study has dealt with professional attitudes towards CAM amongst those medical doctors who are uncommitted to practising CAM. In general, GPs and surgeons distanced themselves from CAM and showed lack of awareness of the regulatory process of CAM in Portugal and the involvement of the Medical Council in CAM regulation. They showed, however, their sympathy for specific CAM modalities such as acupuncture, osteopathy or chiropractic. Even if differences of opinion were evident in the views on CAM expressed by these medical doctors, overall both GPs and surgeons seemed more eager to legitimise the role of acupuncture than of homeopathy in healthcare. This is in line with previous research (Kelner et al., 2004) which shows how leaders of established health professions in Ontario, Canada clearly did not regard CAM as a homogeneous entity.

Four core themes emerged from the data analysis: (1) the jurisdictional limits of CAM; (2) evidence-based CAM; (3) CAM as a residual choice or a last resort (4) CAM regulation and professionalism. These themes represent four main conditions essential for CAM to achieve legitimacy, according to these orthodox medical doctors. Only through the narrowing of their jurisdiction, the attainment of a scientific basis, the acceptance of their residual role in health and in healthcare and the achievement of statutory regulation and professionalism can CAM and CAM practitioners acquire legitimacy and recognition by mainstream healthcare. What follows is an exploration of each of these themes in more detail.

Jurisdictional Limits of CAM

Despite GPs and surgeons' reservations about the efficacy of CAM in general, they viewed acupuncture most of the time as an exception and accepted its use for limited healthcare conditions such as musculoskeletal pain. The respondents' accounts of the benefits of acupuncture suggested very often an 'incorporationist scenario' (Saks, 1995) or a 'co-option' (Baer, 2001) of this therapy. Attempts to limit acupuncture to medical conditions that have proven resistant to biomedicine were evident. As a surgeon with 34 years of clinical practice asserted:

[Acupuncture] is the most credible one. ... If they [CAM therapies] happen to have any benefit, perhaps acupuncture is the one for which there is more hope in getting some therapeutic results. For instance, a patient with *back pain* or with another sort of condition such as *a musculoskeletal one*... I believe that those patients [with those specific conditions] who seek acupuncture can get some therapeutic benefit from it. (I44: surgeon, my emphasis)

In the same way, a GP with 11 years of clinical practice expressed the following view in relation to acupuncture and homeopathy:

I'm not aware of recent research, but from my experience I've had patients who have improved for instance in cases of *allergies* or *renitis* with homeopathy. Then *muscular [problems]* as I said before. Like manipulation [of the spine] with chiropractic, osteopathy and also acupuncture. (I38: GP, my emphasis)

The constant reference and positive attitude towards chiropractic and osteopathy among these medical doctors was not without purpose, as the scope of practice of both these therapies, as Bombardieri and Easthope (2000:480) suggest, has a 'clearly defined specialist orientation' (the manipulation of the neuro-musculoskeletal system) and thus has jurisdictional limits. Another GP with 12 years of clinical practice, when questioned about referrals to CAM practitioners, disclosed a tolerant attitude to acupuncture by recommending this therapy to patients:

For *very specific situations*. *Musculoskeletal* [pain] and perhaps some *ear ringing problems*, sometimes *dizziness*, *vertigo*, for which some [acupuncture] techniques can be beneficial, right. And then for *analgesia*, *anxiety*, for which I have to admit that acupuncture can be helpful. And then I've recommended *cosmetic acupuncture*⁴⁰, which is a good option and I've seen the results. At the moment I haven't got any scientific basis to support my referrals but I've had a few cases that have worked ... that anecdotal experience you see ... from people with whom

⁴⁰ The interviewee referred here to body (most of the times facial) enhancement acupuncture, a non-surgical procedure to improve one's overall appearance which can be a potential alternative to cosmetic surgery.

it [cosmetic acupuncture] has really worked ... and I usually say [to my patients] 'look if you want ... you cannot afford having *cosmetic surgery*, but if you want you can go and try *cosmetic acupuncture* and you might get the same good results. Have a go and try three or four times just to see if it works or not. (I39: GP, my emphasis)

As these three accounts reveal, these medical doctors allowed a restricted, sometimes residual jurisdiction to acupuncture by saying that it can be used in 'specific situations' such as chronic musculoskeletal pain, ear ringing, dizziness and vertigo problems, analgesia, anxiety and body enhancement. In doing so, these medical doctors allowed these conditions to be camicised. As another GP pointed out, 'the important thing is to define what CAM's competences really are, how far they [CAM practitioners] can go' (I37: GP). The need to draw the jurisdictional limits of acupuncture was often justified by citing reference to anecdotal evidence of this therapy's results. Both GPs and surgeons usually seemed to give acupuncture the benefit of the doubt. Despite showing concerns about the quality of scientific evidence for acupuncture, they were eager to wait and see what this therapy had to offer. The second GP also advocated camisation of body enhancement and emphasised the economic challenge of CAM to healthcare, by conveying the idea that (cosmetic) acupuncture might be a viable low-cost alternative to deal with certain situations (body enhancement) when compared to conventional procedures (cosmetic surgery).

In contrast to their institution and a faction of medical doctors who embraced CAM (an issue developed in Chapter Eight), and tended to ignore the professionalisation process of CAM practitioners, these GPs and surgeons appeared not to completely reject the role of the traditional CAM practitioner within Portuguese healthcare. For instance, one of the GPs envisaged CAM practitioners as healthcare 'technicians' who do not need to engage in medical training if they restrict their practice to a specific jurisdiction:

I can see that they [CAM practitioners] can be like other healthcare *technicians*, like an *optometrist*, a *nutritionist* or a *psychologist*. I don't think they need to engage in medical training to practise particular ... it depends ... if they're homeopaths and are going to treat illness that's different. But if they're chiropractors they may know only about an area in the same way as the *nutritionist* knows [about nutrition], [in the same way as] the *midwife* just does deliveries ... I think they can, as long as they get adequate training and work only in a specific area. (I37: GP, my emphasis)

Interestingly, this statement shows this GP's reservations concerning homeopathy in comparison to other CAM therapies. The main issue for this respondent is that homeopathy clearly has a problem with its scope of practice. It aims to 'treat illness' in general, thus maintaining a wide scope of practice or a broad range of conditions that it proposes to treat. Although these medical doctors disclosed that they would recognise non-medically trained CAM practitioners, the latter were usually compared to those mainstream healthcare professionals (nutritionists, optometrists, psychologists, midwives) who occupy a lower and subordinate structural position within the Portuguese healthcare system. The same GP said that, despite not referring patients to an acupuncturist, she believed that she should not discourage her patients from engaging in CAM therapies as they might actually achieve good results, as long as she did not foresee any harm in using them:

I'm not going to refer a patient to acupuncture, but if my patient tells me that they've already tried to *stop smoking* with this and that, and seeks my opinion about [using] acupuncture, I say 'yes', as I think that if that is their choice it might actually help them. As long as I think there is no damage, I wouldn't deny [patients the opportunity to use CAM], but I myself I don't refer [patients to CAM practitioners]. (I37: GP)

This GP associated acupuncture with residual medical areas such as smoking addiction and looked at this therapy as a secondary choice that could be used after conventional healthcare options have been explored. Like other GPs, she claimed the right to act as a 'gatekeeper' (Kelner et al., 2004) or an 'arbiter' (Sharma, 2000) of CAM and emphasised the supervisory role of medical doctors, who should remain the main medical authority over the patient and should ensure that there is no harm in using heterodox practices offered by others. This is in line with Kelner et al.'s (2004:922) previous research in Ontario, Canada, where most of the leaders of established health professions 'argued that physicians need to be the gatekeepers for other kinds of healthcare ... [and] that only if a physician does the diagnosis, can the patient be assured that his/her condition does not urgently require conventional medical care'. So, the view of the medical doctor as the 'well-guarded bastion' (Freidson, 1970a:11) of healthcare, an idea which goes back to the late 19th century, was clearly present among these medical doctors.

One surgeon also highlighted the importance of the psychological side of the treatment and disclosed that patients may benefit in this respect by using acupuncture. When

asked about why the Portuguese State is regulating six very specific CAM therapies, this surgeon answered in the following manner:

Perhaps because these six [CAM's], if we think, as they're alternative therapies some of them for centuries, such as acupuncture, they cannot be questioned. Even if it [acupuncture] is not based on scientific facts, right. But ... if the Chinese always practised acupuncture since China was created, I guess ... And this [therapy] is perhaps one of the most developed ones and perhaps can achieve better results and ... at least psychological effects over people, right. The psychological effect counts on many occasions, right. (I34: surgeon)

The considerable status given to acupuncture is apparent in this account. Surprisingly, this surgeon attempted to justify the scientific evidence and efficacy of acupuncture through its ancient roots as a Chinese therapy, a very typical device used by traditional and medical acupuncturists. Another surgeon legitimised the scientific basis of acupuncture in a similar way:

Acupuncture is quite different from *the others*. The difference can be found in the ancient tradition, in books, with quantified evidence, with results, with clear relationships. (I35: surgeon, my emphasis)

So it became clear that a few medical doctors contradicted themselves in their rhetoric about CAM. In the context of differentiating acupuncture from 'the others', this therapy was often rendered legitimate through appeals to historical evidence. Nevertheless, in their rhetoric about CAM as a collective group, as the next section will show, medical doctors often demanded scientific evidence for both therapies.

At the level of the illness, the reference to CAM as an inappropriate option to treat certain diseases such as cancer was regularly mentioned by these orthodox medical doctors. It was thought by many medical doctors that the treatment of tumours belonged to the realm of biomedicine than to the realm of CAM. Even those who had a more tolerant approach to CAM did not accept the idea that CAM could cure cancer. For instance, a consultant surgeon who was working in a NHS hospital disclosed:

I think that none of them have a real curative capacity. They are good complementary ways of medicine or surgery ... let's say, acupuncture sometimes is effective in pain management. So, that's one thing ... and another [different] thing is to use acupuncture and have cancer. Because [acupuncture] doesn't remove the cancer, you see? It's impossible. (I45: surgeon)

The constant reference to CAM's inability to cure cancer was expressed for a reason. As Broom and Tovey (2008, 2007) showed, cancer patients have been amongst the most enthusiastic patients when discussing the use of CAM in their care. In the UK, for instance, Broom and Tovey (2007) have explored the move towards a more integrative approach to cancer care in the healthcare system. They stated that, 'although still sporadic, CAM services are now being provided for cancer patients within some National Health Service (NHS) hospitals and NHS-affiliated hospices in the UK' (2007:551). These places, they said (2007:551), 'are offering selected CAM therapies including (but not limited to) reiki, reflexology, aromatherapy, therapeutic massage, spiritual healing, acupuncture and hypnotherapy', and are delivered by traditional CAM practitioners. The benefits of the integration of CAM services in NHS cancer care for the public legitimacy of CAM therapies and therapists in the UK have therefore been real. This move towards a more integrative approach to cancer care does not seem to have happened at the level of orthodox Portuguese medical doctors. Depreciatory stories about CAM practitioners who use CAM as a panacea for patients with cancer or other serious (chronic) conditions were very common in the rhetoric of these medical doctors who were not committed to CAM. For example, the following surgeon evoked the case of a patient with multiple sclerosis who opted to be exclusively treated by CAM and ended up dying:

I can remember the case of a well known Portuguese public figure and a very interesting man who had multiple sclerosis without effective treatment. He was an atheist, a fascinating person, and he opted for CAM. He died exactly in the same way [as he would have died with biomedical treatments], within the same timeframe, perhaps suffering a bit less because he had the hope that someone would treat him, right. (I35: surgeon)

At the level of the doctor-patient relationship, this statement is a good example of a clash between the medical knowledge and the patient's subjective experience of the illness, in this case, multiple sclerosis. Also, it subtly suggests the necessity of looking at CAM practitioners as persuasive actors who have been able to convince sufferers with untreatable conditions that they will be cured.

To summarise, these orthodox medical doctors demonstrated some collective opposition to unlimited camisation. It seems that the prospect of accepting CAM and CAM practitioners in mainstream healthcare takes into account the jurisdictional limits of CAM and the subordinate position of CAM practitioners in delivering healthcare. These

are two typical devices used by dominant groups to protect their privileged position inside the healthcare market. They accepted certain degrees of camisation, particularly in relation to ‘contested illnesses’ (Barker, 2010), i.e. illnesses that exist ‘... somewhere between a medicalized and nonmedicalized condition’ (Barker, 2010:152) and thus are open to alternative professional beliefs, diagnosis and treatments. Another theme emerging from the data was the importance given by these orthodox medical doctors to CAM’s scientific efficacy. We will now consider this theme.

Evidence-Based CAM

In spite of the fact that many GPs and surgeons were generally positive about the utility of acupuncture for specific conditions, they were unanimous in expressing concerns about the lack of scientific evidence for CAM, which seems to be the dominant discourse of demarcation of their professional body, the Medical Council. Most of the respondents wanted CAM to adopt the rules of evidence-based medicine (EBM). As a consultant surgeon working in a NHS hospital disclosed:

... I think that when they [CAM practitioners] do things, they don’t do it under well-defined *guidelines*, with *protocols*. Many times they are ... and I think that when they go on TV, they often haven’t got *the knowledge* to say what they usually say. I think that they *talk too empirically* [my emphasis]. They talk about empirical knowledge which was transmitted from generation to generation, right. And I think that it’s very difficult to use as proof of efficacy. (I34: surgeon, my emphasis)

Underpinning this account is the notion that CAM practitioners lack scientific knowledge and credentials to deal with ill health. Furthermore, the ‘scientific’ transmission of knowledge is associated with standardised guidelines and protocols, and is thus opposed to CAM’s ‘empirical’ and ‘charismatic’ transmission of knowledge (Cant, 1996). The references to the placebo effect of CAM were also common in much of the discourse of these medical doctors:

JA: Do you think these therapies work?

I: They work ... it depends ... But I think that most of them don’t have clear scientific evidence that they work beyond the placebo effect. Homeopathy and acupuncture I think their real efficacy it’s still very dubious. From my point of view, I think that still very little is known about this and the research done [so far] is very dubious in relation to their [acupuncture and homeopathy’s] real efficacy. (I37: GP)

Homeopathy in particular was seen as controversial. It was often attacked for its tenets, such as the serial dilution of the remedies which may leave no evident trace of their essence, or the premise that ‘like cures like’ (*Similia similibus curentur*) (i.e. the principle that cure can be achieved by using remedies that produce symptoms similar to the disease in a healthy person). Homeopathy’s unpredictable benefits were often mentioned and were interpreted as being based on random or placebo logic. Comments such as the following from a GP were common:

I cannot believe in the principle of homeopathy. I cannot believe in that. I don’t believe in homeopathy’s principle. And I know that there are some studies which prove that it [homeopathy] doesn’t do anything, that it’s not effective. (I39: GP)

The mention of the placebo effect and the lack of scientific knowledge of CAM often went hand in hand with the mentioning of the lack of CAM’s credentials by the majority of these medical doctors. GPs and surgeons often stated that traditional acupuncturists and traditional homeopaths are deficient in training and scientific knowledge:

Because it’s like this ... medicine is based on *scientific facts*, which is what we learn in medical schools, it’s not ... how can I say ... well, it’s got laboratory research, clinical research ... [it’s] got guidelines with all the steps that every therapy should go through, following certain [evidence-based] research, in order to detect if a patient has or not a specific pathology and all these things, right. So, the study of tumours and all that stuff. And I don’t think that those medicines [CAM] have the capacity to do that [to diagnose a tumour]. Because of course they’re not gonna ask you for specific tests because ... they don’t know how to interpret them. They also don’t know how to interpret results, I believe. (I34: surgeon, my emphasis)

Evidence-based medicine was in this account greatly associated with higher credentials and practice guidelines, whilst the lack of scientific evidence was regularly associated with the professional amateurism of CAM practitioners within healthcare. This accords with Kelner et al.’s (2004) research on the reactions of leaders of established health professions to CAM in Ontario, Canada, who insisted on scientific evidence of efficacy and safety of CAM as a condition for the latter to gain legitimacy. Scholars (Barry, 2006; Borgerson, 2005) who are critics of EBM, however, have suggested that EBM and its proposed ‘hierarchy of evidence’ have constituted a new paradigm of healthcare in contemporary societies and have been political acts to marginalise CAM within healthcare. EBM was initially defined in opposition to the unstandardised scientific foundation of clinical experience (Timmermans, 2010; Timmermans and Kolker, 2004;

Timmermans and Berg, 2003) and was created ‘... as a tool for greater rationality and autonomy’ (Timmermans, 2010). In other words, EBM has been a solution to practice variation and ‘... to hold clinicians financially accountable for their actions’ (Light, 2000). As Timmermans (2010:314) suggested, ‘in this context, the confrontation of alternative medicine with EBM and RCTs [randomised controlled trials] is interesting because it underscores EBM’s potential to keep out competitors’. As Borgerson (2005:505) pointed out, there are some successful CAM treatments that ‘despite achieving the status of best evidence, have not been accepted into mainstream medical practice’. This has been the case with traditional Chinese medicine herbs to treat irritable bowel syndrome or acupuncture to manage nausea and vomiting, for instance. Both CAM treatments have met the ‘higher’ standard of RCTs but have not been implemented in medical practice (Borgerson, 2005). A third theme emerging from the research data was the notion that CAM is a residual choice or a last resort and this will be discussed in the next section.

CAM as a Residual Choice or a Last Resort

A few medical doctors uncommitted to CAM admitted referring their patients to one or another form of CAM such as acupuncture or osteopathy for specific conditions. Although the majority of these medical doctors disclosed that they did not usually recommend CAM to their patients, when confronted with their patients’ accounts of CAM use, they tended to adopt a tolerant attitude and often looked at CAM as a residual choice. One surgeon described her cancer patients as very open to CAM use and revealed that:

I think that in oncology we are more open to the idea of our patients seeking these [CAM] therapies and we usually say ‘if it makes you feel good, go and try, why not?’ Even if we [the medical doctors] don’t believe that much in [CAM] results. But if the patient believes, that’s the important thing I think. I myself cannot believe in any of them [CAM therapies], but if the patient comes to me and tells me ‘doctor, I’m feeling better’, then I say ‘great. You should go as many times you think you need to get better’. Who am I as a doctor to humanely say ‘no way, you shouldn’t go’? (I44: surgeon)

This statement reports the way this surgeon accepted CAM, by emphasising patients’ choices and decisions in dead end situations for which biomedical treatments are no longer properly efficient. One GP asserted that another legitimate way of accepting CAM is when the medical doctor pretends not to know about their patients’ use of

CAM, whether for ethical reasons (as the Portuguese State has not yet recognised these therapies and the Medical Council still bans most of them) or because they feel they cannot prevent their patients from using CAM and from seeing CAM practitioners:

Even if there are still resistant factions [of medical doctors to CAM], [medical] acceptance is now growing. Like pretending not to see and saying [to the patient] ‘oh, you can go there but I’m not aware about that situation’. Something like this. (I41: GP)

And another surgeon ridiculed CAM by declaring ironically that his tolerance of CAM use among his patients enabled him to escape from ‘heartsink’ patients or problematic patients who often came through the consulting room with ‘physical symptoms that have little or no basis in an underlying organic disease’ (Tan, 2004). They are patients who often evoke frustration in medical doctors:

And if the patient is really boring [me] and I haven’t anything else to offer to them, I’m sure that I’ll send them to any of those [CAM practitioners]. That is a relief to me. But that’s a different thing. This is the top of my list of frustrations. If they [the patients] tell me ‘how about if I go and see a naturopath?’ ‘Look, that would be fantastic, would be really fantastic’. I don’t deny that. I’ve already done that. It’s a means of escape. (I35: surgeon)

In this last statement this surgeon identified a residual role for CAM practitioners in that they could be used to deal with the ‘list of frustrations’ of medical doctors - i.e. with the ‘wastebasket’ (Barker, 2010) of medical doctors which entails those conditions for which biomedicine has not found a proper solution. Some scholars (Barker, 2010; Conrad and Stults, 2008) have called some of these conditions ‘contested illnesses’, chronic fatigue syndrome and irritable bowel syndrome being two mainstream examples. As Barker (2010:153) put it, contested illnesses are ‘frequently called ‘functional somatic syndromes’ in the medical literature’ and none of them ‘are associated with any specific organic abnormality’. In the same vein, another surgeon addressed the limits of medicine and indicated she would consider recommending CAM for medical conditions that had been resistant to conventional treatments:

We in medicine also have our limits. There are [medical] conditions with no cure ... and so that’s why we go for palliative care, at a chemical or a psychological level [the respondent was referring here to hypnotherapy]. Why not [use] CAM then? I cannot see why it [CAM use] wouldn’t be possible. If a terminally ill patient is in such a situation and can no longer get help from conventional medicine, I cannot see why they cannot get someone else’s help, someone who

will give them something harmless, I don't know ... like belladonna⁴¹, or an osteopath who will *relieve their pain*, or acupuncture to block a painful nerve ... why not? (I36: surgeon, my emphasis)

This account attempts to legitimise CAM therapies as a last resort or a residual choice in the healing process of terminally ill patients. The respondent conveyed an image of CAM as helpful in 'dead end' situations for which biomedicine has not presented a proper solution - i.e. in contested situations (pain management) where patients' experiences have challenged medical knowledge and sufferers have had to cope '... with medical uncertainty, scepticism, and disparagement' (Barker, 2010:153). CAM regulation and CAM professionalism were another two themes mentioned by the orthodox medical doctors in this research, to which we will now turn.

CAM Regulation and CAM Professionalism

Several medical doctors were critical of CAM's lack of regulation and professionalism and felt that the government should establish some sort of control over CAM therapies and CAM practitioners, as this would give them the opportunity to put their house in order:

So, there's the need for statutory regulation. Otherwise anyone can set up shop and do anything as everything is permitted, right. ... So, to protect the people but also to protect the best side of these practices, by distinguishing the wood from the trees. (I38: GP)

One surgeon indicated an awareness of the jurisdictional limitations of CAM as a synonym for professionalism and claimed that CAM limits should be regulated and CAM practice should be ethically framed:

The first limit is [having] good sense. *Tout court*. Any professional with good-sense knows their limits. Then it comes down to absolute control over appropriate knowledge, technical and scientific, and the techniques being used, which have their limits too. So, if they have control over the technique and over its effects, then they know their limits. And then there is competency. A competent individual knows how far they can go and when they should stop. (I36: surgeon)

Similarly, a GP emphasised that statutory regulation of CAM would increase the level of responsibility of those who offer these therapies, which would permit them to solidify their relationship with the public:

⁴¹ Belladonna is a plant which is often present in homeopathic pharmacopeia and used as an anaesthetic, for instance.

I think that there is always the chance to get responsibility over this or that through legislation, right. And responsibility is always a safety factor for the public, right. To the patients themselves, [as they] benefit from it. In terms of market competition, it [the regulation] clarifies things. So, I think that regulation [of CAM] would bring benefits. (I41: GP)

This statement is interesting as it shows that the views of orthodox medical doctors not committed to CAM appear to be in line with the Act 45/2003, which, as was shown in Chapter Five, is favourable to the professionalisation of CAM practitioners in the country and does not restrict the practice of CAM to biomedical doctors. Another GP emphasised that public interest in CAM and the therapeutic results of CAM have increased in such a way that the sensible solution now would be the regulation of these therapies:

And then we have reached a point where, whether for therapeutic or public reasons, it's better to regulate [CAM] rather than to hold it up and then it's all about other countries' experience, right, where these activities [CAM] are regulated and there have been advantages taken from that, right. (I39: GP)

The reference to the experience of other Western countries where CAM therapies have been regulated was often a way to legitimise the interest of the Portuguese State in regulating CAM therapies. It seems that for these medical doctors everything was interrelated: the ability to provide more scientific evidence would be an essential step in acquiring statutory regulation which, in turn, would lead to increasing credentialism and therefore the professionalism of CAM.

7.3. Discussion

In this chapter the views of orthodox medical doctors on CAM in Portugal have been analysed. The findings presented here have contributed to answering the following research question: How have orthodox medical doctors responded collectively to CAM practitioners' attempts to influence healthcare in Portugal? The focus of this chapter has been the professional views of orthodox medical doctors uncommitted to CAM and camisation.

The research indicated that these actors appeared to resist unlimited camisation, i.e. unlimited transformation of human problems into problems to be treated by CAM. They discussed the acceptance of these therapies under specific conditions. They were more prone to accept acupuncture, homeopathy and their respective professionals if the latter

agreed to limit their role in healthcare. Although they expressed disbelief about the scientific efficacy of CAM, they felt particularly sympathetic towards the use of acupuncture for some ailments that have shown resistance to conventional biomedical treatments, such as chronic pain. Homeopathy, on the other hand, was usually criticised for its irrational knowledge which does not ‘fit’ into the biomedical framework. These medical doctors emphasised the need for CAM practitioners to acquire statutory regulation and professionalism, as well as evidence-based research, a grand metaphor of modernity. They appeared to distance themselves from CAM, and their professional involvement with CAM seemed to be more the result of their patients’ choices and pressures rather than of their own suggestion.

It could be asserted that in Western society the medical establishment generally supports the institutional framework of the healing process, which is predominantly biomedical. The medical establishment claims therefore that medical doctors must adopt a biomedical approach to healing in their day-to-day practice, by applying rational and specific treatments after etiologically recognising the symptoms. Previous research (Bernstein and Shuval, 1997) has shown that the views of CAM of orthodox medical doctors are likely to be influenced by the institutional position of the national healthcare authorities. In this sense, it is probable that the professional views of the Portuguese medical doctors uncommitted to CAM are partially reflective by the institutional position of the Portuguese Medical Council, which has opened the door to the incorporation of acupuncture but has rejected homeopathy on the basis of its ‘esoteric’ knowledge claims. These medical doctors claimed the importance of evidence-based CAM (EBCAM). In this way, as Bakx (1991:25) says, ‘...“orthodox” [medicine] sets the parameters for what is “marginal” or “alternative”, in this case, on the basis of evidence-based research. This is in line with Gieryn’s (1983:782) research on the rhetoric style of ‘boundary-work’ common amongst scientists (where orthodox medical doctors can be included), who tend to attribute characteristics of science to their work to distinguish the latter ‘... from non-scientific intellectual activities’. Yet as Timmermans (2010) has shown, ‘practice variation’ amongst medical doctors does persist and does undermine the supposed scientific foundation of orthodox medicine. Evidence-based medicine, Timmermans (2010:311) continues, ‘... is a move in the chess game of countervailing powers vying for dominance in the healthcare market’.

Like their institution, orthodox medical doctors showed a willingness to negotiate the

degree of camisation that should operate within the healthcare services. That is to say, they accepted a certain range of conditions that CAM can treat, but they aimed for control over this process. The long-established role of 'well-guarded bastions' (Freidson, 1970a) of healthcare enjoyed by medical doctors would allow them to open the gate to CAM practitioners but only under specific conditions, one of them being the subordinate role of CAM practitioners in relation to medical doctors. They would accept CAM practitioners as 'specialised technicians' delivering therapeutic treatments to patients in very specific circumstances. This would mean the achievement for CAM practitioners of a status already enjoyed by other professionals in Portugal such as nurses, physiotherapists, nutritionists, who were placed in an '... instrumental, lower-status position in the system' (Shuval et al., 2002:1753).

Thus, it can be concluded that in this study orthodox medical doctors not committed to CAM appeared to advocate less than their institutional body the incorporation or the co-option of CAM by the medical profession through the skills of medical doctors. Instead they showed more willingness to replicate a dominant/subordinate model of relationship between the medical profession and the other allied health professions. Nevertheless, whether incorporation or subordination is being suggested, both are typical exclusionary strategies and countervailing actions enacted by orthodox medical doctors in order to '... secure, maintain or enhance privileged access to rewards and opportunities' (Witz, 1992:46). Furthermore, the subordination and incorporation models of CAM at the collective and institutional levels of the medical profession evidenced by this research highlighted the prevalence of a modernist discourse, despite the expansion of CAM and its post-modern attempts to promote pluralism in Portuguese healthcare. Some aspects inherent to these models, such as the claims for scientificity of CAM and the prevalence of a hierarchy of evidence, helped to demarcate the medical profession from other related health professions or would-be professions such as CAM and to reinforce the modernist cult of biomedicine and biomedical knowledge.

The data analysis was also suggestive of 'professional role-taking' (Hirschhorn and Bourgeault, 2005) amongst orthodox medical doctors uncommitted to CAM, as their discourses often conveyed a professional rather than a personal or subjective view of these therapies. For example, a few medical doctors disclosed their personal encounters with and benefits from CAM treatments, in spite of revealing that they would not refer their patients to CAM practitioners. This is important as it may reflect a high loyalty

and value-sharing between these medical doctors and their institutional body. Furthermore, it also suggests differential levels of camisation. That is, for these medical doctors, camisation or the process of promoting CAM treatments and solutions to human problems, appears to be stronger at the level of consumers rather than at the level of healthcare providers.

In this chapter, the responses of orthodox medical doctors not committed to CAM to CAM practitioners and camisation in Portugal have been analysed. We will now turn to an analysis of the responses to CAM practitioners and camisation of orthodox medical doctors who became involved with CAM in the country. This will be the aim of Chapter Eight, where the discourses of ‘medical acupuncturists’ and ‘medical homeopaths’ surrounding CAM will be analysed and discussed.

CHAPTER EIGHT

THE TAKE OVER OF CAM BY MEDICAL ACUPUNCTURISTS AND MEDICAL HOMEOPATHS

8.1. Introduction

In Chapter Seven the collective response of orthodox medical doctors towards CAM, CAM practitioners and camisation was analysed. It was revealed that these professionals' responses privileged their role as managers of healthcare. They were keen on viewing CAM practitioners as subordinate to them and on acquiring control over the scope of camisation within mainstream healthcare. In this chapter, the individual discourses of CAM espoused by 'medical acupuncturists' and 'medical homeopaths' (i.e. medical doctors committed to acupuncture and/or homeopathy) will be analysed. A conceptual and interactional level of analysis will be offered.

As a result of the increasing use of certain forms of CAM by medical doctors, CAM has been incorporated into the biomedical model and co-opted by the medical profession. Chapter Six provided evidence that these new closure strategies of incorporation and co-option of CAM have been used by the medical profession at the institutional level of the Medical Council. Recent research (Kelner et al., 2004) has suggested that the move of the medical profession towards the incorporation of CAM is a way for the medical profession to counterbalance power within the healthcare market and to maintain its dominant position in healthcare. From Saks' (1995a) point of view, the medical profession has attempted to stretch its boundaries (or to broaden its field of action), by moving into heterodox healthcare practices.

Nevertheless, these aforementioned analyses are based on the strategies of institutional bodies. Recent research at the level of the individual practice (Frank and Stollberg, 2004:353), however, has alerted us to the fact that 'the use of numerous forms of heterodox [medicine] and biomedicine is conceivable'. This suggests that notions of the incorporation or co-option of CAM may coexist with other notions in the discourses of medical doctors committed to CAM therapies. According to Frank and Stollberg (2004:353), for instance, some medical doctors have opted for biomedicalising CAM and incorporating it into their 'therapeutic arsenal'; other medical doctors have converted to heterodox medicine or have turned into hybrid practitioners practising biomedicine and CAM interchangeably; still, others have been patient-oriented in that

the way they have determined which medical system they should opt for is by giving authority to patients' voices and patients' demands. Another recent situation is that of those medical doctors who have established integrative clinics often in collaboration (in theory) with CAM practitioners (Hollenberg, 2006; Mizrachi and Shuval, 2005; Mizrachi et al., 2005; Shuval et al., 2002). Indeed, this previous literature suggests that a faction of medical doctors have acted like chameleons (Saks, 1996; 2003), able to strategically change their position towards CAM in order to protect own interests. Furthermore, in doing so, this faction of medical doctors have departed from their colleagues orthodox medical doctors.

In Portugal, in spite of the reservations of orthodox medical doctors towards CAM at a collective level, a faction of fellow medical doctors have become involved with heterodox practices that seemingly contradict the main tenets of their biomedical framework (Saks, 1996). More recently, acupuncture has been regulated by the Medical Council, while homeopathy has been practised by medical doctors, despite still being rejected by the Council. Given the countervailing power of CAM practitioners in Portugal since the late 1990s, it is interesting to explore the professional views on CAM, camisation and CAM practitioners espoused by medical doctors committed to CAM. This chapter attempts to answer the following research question: How have medical acupuncturists and medical homeopaths responded to CAM practitioners' attempts to encroach upon healthcare provision in Portugal? This chapter therefore will specifically focus on the rhetoric of orthodox medical doctors who became involved with acupuncture and/or homeopathy (in total n=11).

8.2. Professional Responses of 'Medical Acupuncturists' and 'Medical Homeopaths' towards CAM, Camisation and CAM Practitioners

It can be argued that the marginalised nature of CAM practitioners and governmental inertia in relation to CAM self-regulation in Portugal have allowed medical doctors to plan responses that deal with camisation and with the countervailing power of CAM practitioners. The research reported here identified three main strategies used by these medical doctors. These are: (1) delegitimising CAM practitioners; (2) taking over CAM and (3) self-improvement. This section will now look at each of them in more detail.

Delegitimising CAM Practitioners

As showed in Chapter Seven, orthodox medical doctors were willing to accept the figure of a traditional CAM practitioner and to transfer to the latter medical tasks mostly associated with the management of residual medical categories. Medical doctors committed to acupuncture and/or homeopathy, however, often attempted to disregard the need for traditional acupuncturists and traditional homeopaths in the healthcare market. These professionals sought to delegitimise CAM practitioners who did not possess a biomedical background or who did not belong to an allied health profession. When asked to characterise the relationship between medical doctors and CAM practitioners, an accredited medical acupuncturist and medical homeopath, stated the following:

It depends on the training of those practitioners. Usually there is a good relationship when they've got good training in [specific] healthcare areas. For instance, a *physiotherapist* who practices acupuncture, osteopathy ... it's easy to deal with them [the allied healthcare professionals] because they know how ... the doctor knows how to deal with them, and they know how to deal with the doctor. *The language is more or less the same.* So, what I've seen in many [CAM] practitioners without, let's say, conventional healthcare training is, above all, a big knowledge gap ... Obviously excluding some cases, but a huge knowledge gap and besides that much arrogance. Why? Maybe because of great insecurity, *they want to know even more than the doctors*, you see. So they are not that modest, you see, and I also think that they [think they] know everything. I often find that [attitude] in these [CAM] practitioners ... Usually they think they are right, that they know more than the doctors. (I23: MA, MH, my emphasis)

This account illustrates some interesting points. Firstly, the participant emphasised the superiority, legitimacy and enhanced status of biomedical knowledge. As the respondent asserted, CAM therapists want to know 'more than the doctors' who should represent the 'well-guarded bastions' (Freidson, 1970a) of healthcare and the highest professional authority within mainstream healthcare. Secondly, this account also suggests a linguistic conflict between non-medically and medically trained CAM practitioners. In effect, as a result of an adherence to a different epistemology, differences in language and terminology were noted by both medical acupuncturists and medical homeopaths. According to them, CAM and the biomedical world have distinctive 'linguistic constructs' (Siahpush, 2000). For example, 'nerve endings', 'receptors' and 'pain block' were contrasted to 'meridians', 'pressure points' and 'yin' and 'yang' concepts. The following accredited medical acupuncturist with a leading position in the accreditation of medical acupuncture in Portugal mentioned the

inadequacy of CAM language in the hospital context:

The traditional Chinese paradigm is so closed within itself, it is so different to the biomedical one that it will always have difficulty in expressing itself for commercial reasons ... and also for semantic reasons ... it will always be very difficult. Imagine someone who is a traditional acupuncturist working in a hospital ... 'look, the *yin* and the *yang* bla bla bla' ... I used to talk like this for a long time too. And how did I manage to interact with my colleagues? Today we are able to talk in a different way. (I25: MA)

The mention of linguistic conflict and confusion was often used as a rhetorical device to reinforce the legitimacy of the established biomedical language within conventional healthcare, thus allowing this type of language to exercise power and authority over CAM language and epistemology. According to the discourse of most of these professionals, CAM practitioners are not needed because there are mainstream health professionals – medical doctors and other established professionals such as physiotherapists – who can translate CAM into a clear biomedical language, and who can deliver CAM treatments. Allied health professions such as physiotherapists, for instance, were healthcare professional candidates in the same way as CAM practitioners are now. Nevertheless, they easily bowed to the principles of medical science and to a subordinate position in the healthcare division of labour, which is a move that CAM practitioners seemed reluctant to accept in the Portuguese context.

This medical acupuncturist insisted on this linguistic conflict regularly throughout the interview, reinforcing the view that homeopathy has not been accepted because it still lacks a well-formed biomedical language that explains the way it works, and so medical orthodoxy cannot manage its esoteric nature. The attempt of medical acupuncturists to demarcate themselves from medical homeopaths on the grounds of greater biomedical acceptance of acupuncture will be further illustrated in Chapter Nine.

The way some medical doctors criticised the lack of credentials of traditional acupuncturists and traditional homeopaths often pointed in the direction of charlatanism. One accredited medical acupuncturist, when commenting on the reasons why the Medical Council used to reject acupuncture, blamed non-medically qualified CAM practitioners for their 'misconduct' and for delaying patients from receiving appropriate medical support:

There was a [Council's] rejection ... it was also because of the misconduct of some CAM practitioners, misconduct in the sense of treating situations which had no indication [for CAM]. Also because the patients tended to delay reporting their illness and then visit the doctor when things had deteriorated considerable ... because of exploitation, sometimes, I'm not saying it was badly intentioned, but ... because [CAM] practitioners sometimes treat illnesses which they know they cannot treat but they keep treating... (I25: MA)

It appears clear from this account that the problem for this medical acupuncturist is with CAM practitioners and not with CAM therapies (in this case, with acupuncture). This respondent highlighted 'patient exploitation' that can place patients at risk of not being given appropriate medical treatment. He also blamed CAM practitioners for their undefined competences and scope of practice which can cause delayed access to proper medical guidance, and can consequently pose substantial health risks to patients. Interestingly, this respondent suggested that patients relied on CAM providers and CAM treatments in the first instance. When describing his first professional experience with acupuncture while attending a course on this therapy, this same participant distinguished himself from the rest of the attendees, highlighting the fact that many of the people registered lacked a biomedical background:

My first course on acupuncture lasted one year ... there were solicitors, hairdressers, massage therapists, some ... people who didn't have any idea about what health is. I finished the course and then I went to [name of the country] to study for three years. Because I thought I still didn't know anything about acupuncture. ... And here [in Portugal] when I finished curiously I wanted to take a further course before starting work and those who were with me in the course had already set up their clinics. And I was the doctor. (I25: MA)

The critiques of these medical doctors about the lack of basic biomedical knowledge among CAM practitioners went hand in hand with a reference to the CAM's lack of institutional cohesion, which, as some suggested, has prevented CAM therapies from being better positioned in the healthcare market. As another accredited medical acupuncturist also with a leading role in the regulation of 'medical acupuncture' in Portugal stated:

I know that in some [CAM] areas there are fights among them [CAM practitioners] ... because obviously ... the ones who got the responsibility to write those documents [the proposals handed in by the CAM Committee to the DGS] they claim that responsibility ... I mean, they think they're the owners of those [CAM] areas. But there are others with different opinions who don't like to see that, right. (I23: MA, MH)

This respondent was referring to the internal clashes within traditional acupuncture in Portugal mentioned in Chapter Four and Chapter Five. The participant was referring specifically to the clash between the chairman of the *Associação Portuguesa de Acupunctura e Disciplinas Associadas* (APA-DA) and the chairman of the *Associação Profissional de Acupunctura e Medicina Tradicional Chinesa* (APAMTC), this second one also being acupuncture's representative on the ad hoc Committee of the CAM Bill 45/2003. Although the APA-DA's leader is a recognised traditional acupuncturist among the public and within Portuguese medical circle, he is a controversial figure among a faction of traditional acupuncturists, who belonged to the rival organisation APAMTC.

In summary, the empirical data suggests a general attempt by medical acupuncturists and medical homeopaths to delegitimise CAM practitioners or render them immaterial, by ghettoising CAM language within mainstream healthcare. This is not a surprise, as medical doctors often see CAM practitioners as competitors and criticising them can be seen as a way of serving medical doctors' interests. These findings align with Wolpe's (1985) research on the use of acupuncture by medical doctors in the USA in the mid 1980s. Wolpe (1985:414) stated that 'physicians were also concerned about distancing themselves from the untrained 'quackupuncturists' and tended to '... deligitimise the lay practitioner, [thus] opening the way for later takeover of the technique ... once research has demonstrated its effectiveness'. In this way, medical doctors were able to maintain their professional sovereignty. In the same way, Witz (1992:116) showed in the 1990s how the prospect of competition between the medical doctors and a new professional group (in her research, midwives) in England was made irrelevant by the segmentation of the midwifery services' market. As Witz stated, 'midwives for the poor, doctors for the rich' (1992:116). In the case of CAM practitioners, it could be argued that the prospect of their competition with medical doctors has contributed to the fragmentation of the medical profession, as it has given rise to a new category of medical doctor: the medical acupuncturist or the medical homeopath. Furthermore, one might also argue that the current governmental inertia in relation to CAM regulation has allowed this new category of medical doctors to solidify. However, if the CAM Bill 45/2003 is implemented, one could also foresee a form of segmentation and stratification of public demand for CAM services. Non-medically trained CAM practitioners would be regulated but limited to a sphere of competence (likely approved by the medical profession) and to those patients with a 'holistic worldview' (Boon,

1998); medically trained CAM practitioners would mainly incorporate CAM treatments into their biomedical practice and would cater for patients with a 'scientific worldview' (Boon, 1998). Finally, by delegitimising non-medically trained CAM practitioners, medical doctors re-affirmed their ability and their right to offer CAM treatments to human problems. That is to say, they attempted to place discretion in their own hands to promote and supervise the camisation of Portuguese healthcare.

Alongside the delegitimation of CAM practitioners, medical acupuncturists and medical homeopaths also claimed 'professional ownership' (Wolpe, 1985) of acupuncture and homeopathy. This is an issue which is further developed in the next sub-section, where the extent to which these eleven medical doctors have strategically placed acupuncture and homeopathy in relation to their biomedical practice will be analysed.

Taking over CAM

Medical acupuncturists and medical homeopaths could be seen as taking over CAM, because they have embraced heterodox practices. They have attempted to acquire control over camisation and have claimed 'professional ownership' (Wolpe, 1985) of acupuncture and homeopathy. For example, these professionals clearly showed in their professional rhetoric the potential for the incorporation (Saks, 1996) or co-option (Baer, 2001) of CAM. They often stated that they tended to offer their patients a medical approach in which biomedicine is practised alongside heterodox practices (Frank, 2002). This approach, however, most of the time tended to represent CAM therapies as additional weapons to add to the medical armamentarium, rather than potential professions. The rejection of acupuncture as a profession or its transformation into a 'technique' that should be added to medical knowledge is well illustrated by the following accredited medical acupuncturist leader's response when asked if she looked at acupuncture as a profession:

As a profession? No. *For me it's a complementary therapy* and now I think it's a therapy that I've added to the traditional medical ones, like any other therapy. I think it's a complementary therapy. And I think acupuncture ... [we should] take advantage of the best therapeutic way to treat the patient. And I think [acupuncture] is part of a sort of medicine that we can call today *integrative medicine*. By taking advantage of each medicine, of each therapeutic option according to the patient ... (I26: MA, my emphasis)

This respondent referred to 'integrative medicine' and defined it as a medicine which

entails different ‘therapies’ such as acupuncture and homeopathy but remains framed by a biomedical epistemology. As shown in Chapter Four, traditional acupuncturists and traditional homeopaths also talked about ‘integrative medicine’ but attributed a totally different meaning to it. While CAM practitioners referred to ‘integrative medicine’ at the level of interoccupational relationships such as ‘the use of non-hierarchical interdisciplinary teams [of medical doctors, allied health professionals and CAM practitioners]’ (Kelner et al., 2004:921), for medical acupuncturists and medical homeopaths ‘integrative medicine’ consisted of the ‘integration’ of CAM therapies into their biomedical practice and the isolation of CAM from its traditional epistemology. This rhetorical shift of CAM therapies from being ‘potential health professions’ to being ‘medical techniques’ or additional (or complementary) ‘medical tools’ is interesting in that it involves exclusionary aims and seeks to ignore and delegitimise the professional project of CAM practitioners.

The context, degree and level of incorporation of acupuncture and homeopathy emerged as important aspects in the rhetoric of many of the medical doctors interviewed. For example, the context of medical practice was often taken into account when deciding how much of CAM these medical doctors should incorporate into their biomedical practice. A few medical acupuncturists and medical homeopaths disclosed that they often found it difficult to negotiate the degree of incorporation of CAM within a public healthcare context. In the case of homeopathy, for example, this therapy has not as yet gained legitimacy within Portuguese public healthcare. Furthermore, homeopathic treatments, as Degele (2005:126) put it, ‘... are oriented toward the long term. ... Whereas the structure of the consultation in biomedicine is limited to short story taking, in homeopathy, an extensive and careful case built for up to two or three hours is crucial for successful treatment’. The commitment to a type of medicine that dispenses the main tenets of homeopathy, such as time consuming story-telling by the patient, forced them to abandon the idea of adopting a more pluralist medical practice in public healthcare settings such as health centres or hospitals. The following non-accredited medical acupuncturist and medical homeopathic leader blamed the State for having constrained family doctors from practising more comprehensive healthcare in health centres:

In my opinion the State shouldn’t be controlling health. The State should be the regulator and let this [public health service] work and should only invigilate [it]. Because it [the State] doesn’t know what family medicine is. We [family doctors]

should have time to see the patients. But we are pressurised by the State to do exactly the opposite. And sometimes this is upsetting, you see. (I32: MA, MH)

Despite the legitimate (although restricted) use of acupuncture within the public health sector, another non-accredited medical acupuncturist showed resistance to practising this therapy within the hospital setting:

Occasionally I do a bit of acupuncture, because not all the places accept it ... and besides that when I'm in an emergency service I've got a contract which is about practising ambulatory surgical medicine. But in my [private] clinic and in my own practice, one thing is so tied to the other ... after 30 years I can no longer grasp the difference between prescribing [a remedy] or inserting a needle. *I do it together. I cannot grasp the difference between them.* (I14: MA, my emphasis)

These medical doctors disclosed that the demands of the public health sector such as time limitations and professional liability and responsibility, have influenced their utilisation of CAM and have prevented them from adopting more 'integrative medicine'. Degele (2005) predicted the same implications for medical homeopaths in Germany, who, she said, would be compelled to choose between restricted homeopathic practice within the public healthcare system or giving private homeopathic consultations. As Elston (1991) puts it in the case of Britain, offering private medical care has provided medical doctors with opportunities for clinical freedom and professional autonomy (i.e. for controlling their clinical performance). All the medical doctors committed to acupuncture or homeopathy in this study set up or worked in private clinics in addition to their commitment to the public service. Working privately provided them with an unconstrained feeling about combining acupuncture or homeopathic treatments and biomedical procedures such as prescription. Some of them disclosed that when working privately they became more 'holistic', often contemplating the main tenets of acupuncture and homeopathy which they had been encouraged to discard when working in health centres or in the hospital setting. For instance, an accredited medical acupuncturist and medical homeopath commented that in her private clinical practice she sometimes opted for using acupuncture, not as a complement, but as an alternative to conventional analgesia:

For instance, in my private [medical] practice I often use acupuncture as a complement and at other times I only use acupuncture, as *an alternative, for instance, to a [conventional] analgesic.* (I23: MA, MH, my emphasis)

Another factor affecting the degree of incorporation was patients' choices and demands.

A considerable number of the respondents alluded to a consumer-oriented approach towards acupuncture and homeopathy. They disclosed that the extent to which they combined these therapies with conventional treatments varied according to the clinical context and the wishes of the patient. One medical homeopath and accredited medical acupuncturist blamed the patients for constraining his use of acupuncture and homeopathy in his clinical practice:

Because I treat many patients who have cancer, and I use it [acupuncture] as a complement. I don't use it as an alternative *because the people wouldn't dare*. (I27: MA, MH, my emphasis)

This same medical doctor confessed to having set up a patients' list with the names of those who were sympathetic to homeopathy and who had agreed with being treated by this therapy. These findings converge with previous research on medical acupuncturists in Germany who, as Frank and Stollberg (2004:367) put it, have segregated 'their patients into categories of homeopathic and biomedical patients in a consumer-oriented way'. Another accredited medical acupuncturist who dedicated most of his clinical practice to private consultations in 'medical acupuncture', when asked why he had committed himself to this therapy, referred to the influence of lay opinion. In addition he proclaimed that there are multiple ways of legitimising a healing technique with the power of patients' voices being one of them:

There are some reasons [why acupuncture is getting popular amongst doctors]. One of them is the use ... let's say ... the legitimacy of a technique There are many ways of being legitimated. Through *lay opinion* ... even if it [lay opinion] shouldn't be given so much importance ... and it [lay opinion] has started spreading, I mean, if there are some people who feel better [using CAM], they keep telling others, [who tell] their doctor ... (I25: MA, my emphasis)

This statement is interesting as it shows how this respondent highlighted the authority of lay opinion or the voice of 'lifeworld' as a 'countervailing power', in that it had affected the degree of incorporation of certain heterodox practices into his biomedical practice. Light (2010:271), in his recent review of the relationship between the medical profession and markets, alerts us to the same fact, by stating that '... patients have become an increasingly important countervailing power'. This empowerment of the patient, then, is at the heart of what has been called postmodernity, where '... the populace must be constantly questioning – reflecting not only on the conditions of their own lives, but also on the authority of others' (Annandale, 1998:229). Yet this

respondent also tried to delegitimise the patients' voice by underscoring its untrustworthy nature.

These last two medical doctors, along with two others, showed signs of 'conversion' to acupuncture and/or homeopathy at the level of daily medical work. They can be labelled as 'detached', as they had detached their medical practice from the national health system and had set up private clinics where they advertised their use of CAM in their clinical practice. The following 'detached' medical doctor gave an account on what acupuncture meant to him:

I only practise a little of medicine. So, my medical practice isn't enough for me to live. In that sense, acupuncture is a profession. But I'm not the rule. Doctors for the most part ... acupuncture is a technique that they use but normally they still practise their [medical] activity. They are GPs in the public healthcare service ... I'm on unpaid leave ... they're orthopaedics, physiatrists⁴² and spend x time using this technique [acupuncture]. So, in that sense, it's not a profession for them. But it is for me I believe. (I25: MA)

For this respondent, acupuncture is a profession mainly because it is a paid occupation and the primary way of earning a living. He contrasted himself with his colleagues medical acupuncturists who he believed had incorporated acupuncture as a technique in their biomedical practice. While his medical acupuncturist colleagues remained State employed, this respondent had nearly detached his medical practice from public medical care and had opened his acupuncture practice by entering the private health business.

However, even the 'detached' medical doctors often thought of themselves as sheltering behind their profession. For example, at the conceptual level, higher degrees of incorporation of CAM prevailed. Some of the respondents found it difficult to accept terms like 'medical acupuncturist' or 'medical homeopath', preferring to call themselves conventional medical doctors who practised acupuncture and/or homeopathy. The prevalence of a biomedical framework and the incorporation of CAM at the conceptual level through the translation of homeopathy into a biomedical technique are illustrated by one 'detached' medical doctor, a medical homeopath and accredited medical acupuncturist:

Don't say that I'm a homeopath because I use what I think is the best for you, and

⁴² A medical doctor with a speciality in physical rehabilitation medicine.

what's the best for you is a mixture of different things. (I27: MA, MH)

When asked about the conditions for which they used acupuncture, these medical doctors, including 'the detached' respondents, mentioned conditions with greater scientific evidence of acupuncture's benefit (although they often concluded by stating that acupuncture can be used for nearly all clinical conditions). One detached doctor, for instance, presented a leaflet with a list of conditions for which he advertised acupuncture, with pain management ranked at the top of the list. He later added that the clinical conditions appearing in the leaflet are the ones 'where acupuncture can be used with a greater chance of success' and emphasised the following:

... I did that [the leaflet] thinking about an average patient and I did it in such a way that if a health professional, a medical doctor, one of my colleagues, looked at it [the leaflet] they wouldn't say 'this guy is a liar'. So, everything which is in there is backed by detailed studies already. (I25: MA)

This statement espouses an elegant position which has been generally adopted by the medical acupuncturists in the country. Usually they claim increasing scientific evidence of the effectiveness of acupuncture and refer to pain management as one of the core jurisdictional areas of this therapy. Their fear of being distrusted by their peers has made them more cautious and therefore more mainstream, cooperating with the medical establishment in the promotion of the incorporation of acupuncture into mainstream healthcare. Nevertheless, in spite of their efforts not to be labelled as 'deviant' doctors, 'dissenters' (Goldstein et al., 1987) or 'medical heretics' (Wolpe, 1990), they clearly claimed a broad scope of practice of acupuncture, which goes beyond that legitimised by the Council and by their peers. That is to say, they wanted to play an active role in the camisation process.

In the case of homeopathy, the analysis also showed a great emphasis expressed by most of the medical homeopaths on conditions for which the effectiveness of this therapy has been proven greater: persistent respiratory and infectious diseases in children, allergies and skin problems. Although once again an extended list of conditions was referred to, some of those even overlapping with acupuncture's healing areas. The following statement illustrates very well the high level of confidence and deep engagement of a medical homeopath and accredited medical acupuncturist with the use of homeopathy:

Send me a patient with allergy problems or children with *persistent sore throats* or something easier. *Send them to me and you'll see if I don't get good results.* ... Because I haven't yet had any unsuccessful cases in children and adults with persistent sore throats, and some of them [the patients] were nearly about to undergo surgery ... and *ear infections* and ... and [at the end of the day] they didn't need to undertake surgery. And that [homeopathy] broke the vicious circle. I just want to make a bet, that's it. I mean, send them [the patients] to me and I'll treat them. (I27: MA, MH, my emphasis)

In summary, the appropriation of CAM by medical doctors through the adoption of an incorporationist scenario (Saks, 1995a) where CAM therapies have helped to expand their biomedical action and jurisdiction was well evidenced in this chapter. As Lowenberg and Davis (1994:581) aptly stated, by incorporating CAM medical doctors have enlarged 'the traditional sphere of medical (read 'allopathic') concerns from a narrow, largely technical focus on symptomatology and disease to a broadened domain including such health salient foci as nutrition, psychological and spiritual well-being, interpersonal relations and influences emanating from the environment'. Interestingly, this jurisdictional expansion, with an emphasis on psychosocial issues, was also a strategy used in the past by other medical doctors. Halpern (1990), for instance, illustrated the case of psychosocial paediatrics in the USA. As he stated, by the mid-1950s paediatrics was seen as a monotonous and routinised speciality and the creation of behavioural paediatrics, with its emphasis on social and behavioural disorders in children, was a way of making paediatrics more stimulating work.

The public/private health context and patients' choices, however, seemed to affect the degree of incorporation of CAM into biomedical practice. Furthermore, four medical doctors suggested signs of conversion to CAM at the level of daily medical work. These 'detached' doctors however, although standing apart from the public health sector, had not completely exited it, as they were placed on unpaid leave. This aspect reinforced their chameleonistic nature or their '... capacity to acquire new skills, spatial mobility and general malleability, to adapt to a highly volatile job market' (Soley-Beltran, 2006:35). We now turn to a third type of strategy used by medical acupuncturists and medical homeopaths for dealing with CAM, camisation and CAM practitioners, namely self-improvement.

Self-Improvement

Self-improvement involves the manner in which medical acupuncturists and medical

homeopaths have repaired aspects of medical practice that they claimed had been lost over time and on the basis on which CAM practitioners had attempted to achieve jurisdiction. Rescuing old ‘legitimacy values’ (Abbott, 1988), which was part of the character of the medical profession in earlier Hippocratic times, was presented as an example of self-improvement by medical acupuncturists and medical homeopaths. Holism, idiosyncrasy, clinical experience and pragmatism were predominant examples of old legitimacy values expressed by these professionals. The motivation for this evocation however, from a social closure perspective, was the mobilisation of the means of closure and of the appropriation of CAM. At the knowledge level, the rescue of old legitimacy values entailed an exclusionary strategy of ‘reskilling’ medical doctors. In other words, medical doctors have reskilled themselves with old medical values in order to eliminate the need for CAM practitioners and to protect themselves from recent CAM practitioners’ attempts to encroach upon mainstream healthcare provision. We will now consider each of these ‘legitimacy values’ in turn.

Holism

Of importance here was the fact that all the medical acupuncturists and medical homeopaths echoed holistic notions of healing. They expressed claims about the need to look at the whole person and concerns about the prevailing biomedical approach in the clinical encounter. One medical homeopath and non-accredited medical acupuncturist commented on the importance of the spiritual side of the healing process:

There’s an expression by a French surgeon whose name I cannot remember now, which is *I never found a soul on the tip of my scalpel*. Actually he was right as the patient’s soul can never be found in the tip of a scalpel. And of course if we opt for a more global approach to the patient, they [the patients] won’t be only flesh which will be cut out by a scalpel. It’s more than that. And that approach, of the patient as a person, with their different sides ... obviously the *physical* side, but also their *psychological* side, their *emotional* side, their *spiritual* desires... it’s as if the human-being was made of different bodies. Actually they [the esotericists] talk about that in esoteric schools⁴³. (I33: MA, MH, my emphasis)

This quotation discloses the idea of the human being as having ‘many bodies’, a notion that was not exclusive to this respondent. Again, there was an attempt to broaden the biomedical domain to other spheres such as the spiritual, the emotional and the mental. This last respondent used a metaphor to criticise the Western duality between the

⁴³ Schools or philosophical branches that claim the existence of a cosmic and spiritual evolution. In this sense, their knowledge system is esoteric, i.e. heterodox.

‘flesh’, associated with a reductionist and rational approach to health, and the ‘soul’, related to a wider, holistic approach to health. He then gave credit to the esoteric school of thought, which, he said, is more likely to contemplate all sides of the patient with its approach towards the human being, which was the correct one for him. In the same vein, a medical homeopath and accredited medical acupuncturist spoke about the dominance of the biomedical discourse over time and the subsequent abandonment by medicine of the psychosomatic level of the human being:

So, medicine had a great period after the discovery of the bacteria, the microscope, Fleming’s penicillin ... So, we’re in the 1920’s, where we got evidence ... and that was fascinating [to know] that the antibiotic attacked the bacteria and some conditions which were unlikely to get cured were actually treated ... well, this gave a big emphasis to medicine during that period, to the laboratories ... and then there were some other older medical parts which were left behind, some of them related in fact to the psychosomatic, such as the case of homeopathy. (I30: MA, MH)

This last statement suggests that older ways of health production such as homeopathy were left behind in the pursuit of a more scientific-oriented medicine. As Santos (1987) has declared, it is somehow perplexing that those same old ways of health production have themselves been evoked (by different social agents and at different levels) as the reverse of scientific medical progress. Similarly, another accredited medical acupuncturist and medical homeopath, when talking about the recent weaknesses of conventional medical practice, echoed the view that adopting holistic measures such as a good relationship between the medical doctor and the patient could account for ‘fifty per cent of the treatment’:

Conventional medicine is too compromised by pharmacology and lost ... this is because of governmental pressures too, you see ... what matters is the numbers [treated] ... it isn’t the quality that matters but the quantity. And there is no time to pay enough attention to the patient. And this is exactly what the so-called non-conventional therapies offer, you see. Paying more attention to the patient, and this is, let’s say, *fifty per cent of the treatment*, of getting results. (I23: MA, MH, my emphasis)

The importance given to the doctor/patient relationship was one of the most frequently mentioned issues among the medical acupuncturists and medical homeopaths. This is in line with Goldstein et al. (1985), who showed how holistic doctors in the USA emphasised the doctor-patient relationship in mainstream medicine as narrow and artificial. Interestingly, one medical homeopathic leader and non-accredited medical

acupuncturist mentioned how prescribing has eclipsed other aspects in the doctor/patient relationship:

And we also as doctors, in relation to the patient, we no longer care about the patient. The patient comes in ... 'so, what's the matter with you?' We prescribe something and ... we don't talk with them, we don't ask for their story telling, for their problems in life, we no longer approach these topics which are crucial to identify health or illness, right. (I32: MH, MA)

Another medical homeopath and accredited medical acupuncturist drew attention to the length of his consultations in the private health service and the need for active collaboration between the doctor and the patient. His next statement highlights the use of medical trends from earlier times, where the patient's story-telling was the key to diagnosis and management of illness:

Normally my consultations last *an hour and a half, two hours*. First because sometimes I get [patients with] complicated or chronic pathologies who have been in many places [who have seen other professionals] and [they] seek me out hoping that I'm a *healer* who will sort them out. ... The consultation is ... it's not just doctors talking to patients but instead it's a *team work*, which is more the other way round ... (I27: MA, MH, my emphasis)

This last statement is also interesting as it shows how this 'detached' medical doctor defined himself as a 'healer' in relation to his patients and his peers. The concept of 'healer' is often associated with someone who reinforces esoteric (i.e. heterodox) components of healing in their medical practice. Intra-occupational issues such as the way medical acupuncturists and medical homeopaths positioned themselves in relation to their more orthodox colleagues are discussed in more depth in Chapter Nine. This same respondent also conceptualised the consultation as 'team work', in opposition to the current hierarchical doctor-patient relationship where there is little scope for the patient's voice. He disclosed later on that he had detached his medical practice from the public health service because of the institutional pressure to shorten the length of his consultations, which he blamed for spoiling the doctor-patient relationship:

I was pressured many times... 'You need to see more patients, you need to see more patients'. And I had to decide whether I did what I did which was leaving the health centre and asked for unpaid leave, or rather keep being dishonest. Because if all the doctors said 'no way, I regret doing that [shortening the length of consultations] because I'm decreasing the quality and I'm running some risks ... Because that's true, *in fifteen minutes you cannot make a good quality consultation* nor ... may be with simple things that's fine, but with more serious things some stuff might be missed. *You need half an hour or one hour*. You need

to get into family problems ... even for that sometimes you might need more time. (I27: MA, MH, my emphasis)

In summary, the reference to holistic leanings of medical practice and to a patient-oriented approach within the consultation (two aspects over which CAM practitioners have attempted to acquire jurisdiction) illustrated these medical acupuncturists and medical homeopaths' attempts to rescue older components of medical practice. This strategy of rescuing old legitimacy values thus entailed the 'reskilling' of medical doctors which, within a social closure approach, could be seen as an attempt to minimise the impact of CAM practitioners and protect medical doctors' control of healthcare. We will now see how these respondents also tended to evoke clinical idiosyncrasy in their medical practice and how this is clearly an example of self-improvement related to their profession.

Idiosyncrasy

Similarly, the unique experience or idiosyncrasy in the healing process was referred to by most of the medical acupuncturists and medical homeopaths as another important dimension of healing. In short, like traditional acupuncturists and traditional homeopaths, medical acupuncturists and medical homeopaths emphasised the subjective and individualised character of healing and stated the influence of the patient in successful treatment. As a medical homeopath stated about homeopathy:

There are patients with whom I think I should do homeopathy, for instance ... but I'm not sure. Because I know that that person who's in front of me won't comply. They won't do it. It's impossible. Because of their temperament, their way of being. They are not gonna do it, I'm sure. So, I prefer not to do it. ... But a patient who has a certain kind of temperament, a person who has a disposition to [CAM], and has been educated, let's say, to deal with healing in a different way ... or among children ... then I use it. Of course I use it and with good results. Without a doubt. (I28: MH)

The distinction between patients with a personal disposition to CAM and patients who are not 'tailored' to use CAM therapies, and also the way these different dispositions might influence CAM treatment, was made clear by this respondent. Another accredited medical acupuncturist leader, who overtly agreed with the exclusive use of acupuncture by medical doctors, when asked if this therapy works, compared it with the uncertainties surrounding patients' reactions to anaesthetics and gave the following explanation:

It does work. But I should say that there are complicated situations where we cannot say to the patient ‘look, you’ll get cured’. Because *each case is a case*, each patient reacts in a very specific way, and I very much compare acupuncture with anaesthetics. I think each case is a case. That’s it. (I26: MA, my emphasis)

The expression ‘each case is a case’ presented in this last quotation is again well-illustrated by the following medical homeopathic leader when talking about the treatment of sore throats:

JA: So, ten patients with a sore throat ...

I: There will be ten different sore throats. We often simplify and sometimes things work more or less well. That’s like I said. Homeopathy, in order to be a homeopath, you need ... because when you open a book about homeopathy, it seems that those remedies will work with any condition. And in fact they work on everything. I mean, a remedy in a certain person can heal haemorrhoids, but in another person can heal a faringitis [sore throat]. And still in another person can heal hair loss. It involves many variables. It’s extremely complicated. (I29: MH)

This same respondent disclosed later on that ‘I believe that *typifying patients* [my emphasis] is impossible to do’. Another medical homeopath, fellow member of the *Royal London Hospital for Integrated Medicine* and also a phytotherapist, when referring to her broad knowledge of her patients’ psychosocial context, interestingly stated that ‘... I nearly foresee who is gonna get ill and why’ (I31: MH). This last statement shows how this medical homeopath used the extensive knowledge of her patients’ biographies to legitimate her wisdom in ensuring who had the potential to become ill.

To summarise, looking at each patient as ‘only one of its kind’ has made medical acupuncturists and medical homeopaths emphasise older values and principles of medical practice that have now been claimed by CAM practitioners. One can also observe here the shift from focusing on the disease to focusing on patient’s health preferences. The use of CAM treatments among medical acupuncturists and medical homeopaths however, in the same way as among traditional acupuncturists and traditional homeopaths, seemed to remain dependent on patients’ demands and patronage. We will now turn to a third main theme evoked by medical acupuncturists and medical homeopaths which can also be viewed as an act of rescuing older models of medical practice, the emphasis on clinical experience and pragmatic healing.

Clinical Experience and Pragmatism

Of importance here was the way in which many of the medical acupuncturists and medical homeopaths valued the historical context, tradition and clinical experience as legitimate evidence of CAM's success, thus contradicting many of their more orthodox colleagues. One non-accredited medical acupuncturist, while talking about the appealing use of the *omm* sound in his medical practice, stated that:

I've learned that if it [the *omm* sound] remains in human history that must be for some reason. That's the same with acupuncture. If it has been part of the human history for 3500 years and more ... 2000 years, then this must be for some reason. Perhaps over these years many religious practices about God and everything which is the God of the Sun, the God of whatever, they were left behind. They weren't strong enough to stay. Only the strongest stuff still remains. And one of them was acupuncture. And the other one was the *omm sound*. So, what is shown to be robust remains over time. (I14: MA, my emphasis)

In the same way that traditional acupuncturists showed resistance to evidence-based acupuncture, this medical acupuncturist attempted to legitimise alternative standards of evidence for this therapy: the authority of the past and of tradition. The emphasis on alternative standards of evidence of acupuncture reminds 'authority-based medicine' of the past, based on the authority of the physician, tradition and clinical experience (Borgerson, 2005), and practised by medical doctors until the recent advent of evidence-based medicine (EBM). The importance given to the authority of clinical experience is clearly highlighted by another medical homeopath who, while talking about homeopathy, stated the following:

Everybody knows that the Achilles' heel of homeopathy is the lack of scientific evidence. Everybody knows that, right. If I haven't got, let's say, a way of measuring something, because it hasn't been invented yet, you see, how can I prove, how can I do that, you see. So, I often find myself ignoring that and *basing my practice on my own clinical experience*. (I28: MH, my emphasis)

The idea expressed in this last account, that homeopathy continues to be rejected because 'science' has not progressed enough to find an explanation for the way this therapy works, was shared by most of the respondents. Furthermore, the reference to anecdotal clinical cases, which are considered to have lower value in the hierarchy of evidence proposed by the EBM movement, was often an alternative way of legitimising homeopathic practice. In the same vein, another medical homeopathic leader explained that, when confronted by patients about the efficacy of acupuncture, he often based his

answers on his clinical experience:

Logically, if every time that a patient gets a specific type of sore throat I give him mercury and belladonna⁴⁴ and he gets cured, then ... every time that this happens ... well, the first time I will say 'well, may be he'd get cured anyway'. *But after fifty times* I may say 'look, it seems that actually there is a cause-effect relationship here'. And I think that *that experience over time* is more important than any kind of well standardised study... because this type of studies often doesn't match the reality. (I29: MH, my emphasis)

These quotations illustrate the attempts of these medical doctors to eschew evidence-based medical practice and to legitimate 'lower' forms of evidence of CAM. Like the traditional acupuncturists and the traditional homeopaths, medical acupuncturists and medical homeopaths appealed to difference and requested special treatment for CAM (Borgerson, 2005). As Borgerson (2005) put it, because CAM cannot meet the standards of EBM, it should not be subjected to the same standards of evidence as mainstream medical practice. In this last statement clinical and personal experience is used to establish causal relationships between CAM treatments and their results. Once more, medical homeopaths and medical acupuncturists put an increasing emphasis upon clinical experience or 'clinical legitimacy' (Willis, 1994), which was the foundation for biomedical research and on which biomedicine used to depend in the past. They also undervalued standardised research and clinical trials, on which they claimed biomedicine is currently over dependent. Evidence-based medicine was not therefore seen as a panacea for medical practice among these medical doctors committed to CAM.

Surprisingly, these medical acupuncturists and medical homeopaths also legitimised acupuncture and homeopathy through their resulting benefits and accepted unconventional ways of achieving such benefits. They portrayed healing as a very exploratory process and emphasised the importance of spiritual-oriented techniques such as the *omm* Buddhist sound:

I: *What I'm really interested is in getting results.* If there's the need to go and sing the *omm* sound or whatever ... I don't mind. It wouldn't be the first time I've done it. The *omm* sound has a deep vibrating power. Do you know the *omm* sound? (I14: MA, my emphasis)

This quotation represented the point of view of a non-accredited medical acupuncturist

⁴⁴ A plant which is often present in homeopathic pharmacopeia and used as an anaesthetic, for instance.

who legitimised the *omm* sound as a technique to achieve results. It represents one of the most interesting accounts from this research, as it illustrates the cohabitation of alternative forms of envisaging the healing process in medical discourse. The *omm* sound is seen here as an alternative technique for achieving a medical result in spite of remaining associated with a mystical and magical world undervalued in biomedical thinking. Another medical homeopathic leader designated the act of praying as having potential benefits for the patients:

I think that [medicine] should be critical but also more open to all ... to all possibilities, as long as it can be found there [in other ways of healing] a bit of a logic, but sometimes that logic is a bit difficult to define, because ... I don't know if *saying three Hail Mary's for those who believe in God* and all that stuff... *if it could be useful and sometimes I believe it could be*, I'm not sure. So, it's not easy to define what the meaning of *truth* is. (I29: MH, my emphasis)

In short, the underlying idea of these last two statements is that singing therapy, faith, spiritual or charismatic healing are perceived as ways of achieving results. That is to say that medical acupuncturists and medical homeopaths emphasised the explorative path that the healing process can entail. They accepted that clinical practice is more likely to be successful when concentrated on 'useful' rather than 'scientific' means of achieving results. As Chapter Four showed, this is a claim that was often found in the discourse of traditional acupuncturists and traditional homeopaths. As the following quotation from one medical homeopathic leader and non-accredited acupuncturist illustrated:

The scientific doesn't exist for me. For me the meaning of scientific is to treat the human-being which is the patient. (I32: MA, MH)

This last account evokes the philosophical ideas of pragmatists such as Peirce, James, Dewey and Mead, for whom the 'pragmatic usefulness' of an approach towards a certain goal is what should make it more or less 'scientific' (Lewis, 2007). In other words, the more helpful one approach proves to be, the more scientific it should be considered. It matters little therefore that clinical care is monopolised by one dominant approach (also referred to by these scholars as 'model', 'belief' or even 'philosophy'), as often this approach can be impractical or unsuccessful in achieving clinical goals. As Goldstein et al. (1987:104) put it, 'folk knowledge, insight, spiritual revelation, and an ability to gain access to a variety of currently immeasurable phenomena are all regarded as potentially important', as long as they show they are useful in achieving clinical success.

Finally, another medical homeopath and accredited medical acupuncturist emphasised what Hirschhorn and Bourgeault (2005) described as the slippage of personal and professional views of more orthodox medical doctors towards heterodox practices:

Because if somebody ... if a doctor, they could be very conventional, but if they had a son who was dying and knew that *Jesus Christ* was there and would heal him, he'd get his help, let's be honest. He could criticise before and after, but he'd get his help. So, if I knew some people with a *gift* to heal, as they do in the United States, I'd integrate in a big team a priest, a sociologist, a psychologist, anybody. Even an illiterate with a particular *gift*.' (I27: MA, MH, my emphasis)

This last account attempts to legitimise a pragmatic approach to health by hypothesising potential changes to the attitudes of his more orthodox colleagues towards CAM if they experienced strains in their family lives. By emphasising dramatic incidents, the respondent was able to highlight the inconsistency between personal and professional attitudes of fellow medical doctors towards CAM. According to this respondent, although more orthodox medical doctors tend to adopt more institutional views on CAM by reiterating the rhetoric of their healthcare authorities such as the Medical Council, they would embrace CAM treatments and they would change their thinking about healing if they experienced dramatic incidents in their personal or family lives.

In summary, pragmatism in healing was a main legitimacy value referred to by medical acupuncturists and medical homeopaths in this study. By emphasising clinical experience, history and tradition as legitimate evidence of CAM's effectiveness, medical acupuncturists and medical homeopaths tried to rescue old legitimacy values of medical practice which were left behind with the advent of evidence-based medicine and the standardisation movement in healthcare. As Timmermans and Berg (2003:13) stated, before the advent of the standardisation movement, 'the content of the work itself was left unaddressed: to decide the proper course of action for a given solution was the unique prerogative of the individual professional'. It is thus interesting to note that the claims of medical acupuncturists and medical homeopaths from this study involve returning to a more professional-based rather than evidence-based clinical performance.

8.3. Discussion

This chapter has sought to answer the following research question: How have medical acupuncturists and medical homeopaths responded to CAM practitioners' attempts to

encroach upon healthcare in Portugal? This chapter has specifically focused on the rhetoric of medical doctors committed to CAM, on CAM, camisation and CAM practitioners.

The recent countervailing power of CAM practitioners has challenged mainstream healthcare and has provoked responses from stakeholders such as the medical profession. The latter, in the face of CAM challenges, has adopted countervailing strategies to maintain its sovereignty (Kelner et al., 2004). Sociological approaches which have opted for a social closure and market-based perspective in explaining why medical doctors have become involved with CAM have emphasised the traditional willingness of the medical profession to do everything possible to maintain its higher power and status, especially when confronted by changes in the regulation of healthcare markets (Kelner et al., 2004).

This sociological stance helps explain the current situation in Portugal. The main occupational strategies of closure employed by medical acupuncturists and medical homeopaths to deal with camisation and CAM practitioners' strategies to influence Portuguese healthcare have been the main focus of analysis in this chapter. It was shown that delegitimising CAM practitioners, taking over CAM therapies and self-improving individual medical practice were main strategies of medical acupuncturists and medical homeopaths. Medical doctors who embraced CAM sought to ghettoise CAM practitioners (picturing them as irrelevant to healthcare), promote CAM therapies as 'techniques' to be hosted by biomedicine and provided by medical doctors, and reskill themselves with old legitimacy values of medicine. In this way, they have been able to expand their field of action in an attempt to maintain control over healthcare. As was shown previously, this contrasted with the responses of those medical doctors not committed to CAM, who were willing to accept the professionalisation process of CAM practitioners on a subordinate basis, and who were willing to accept acupuncture and homeopathy as professions. Furthermore, many claims of medical acupuncturists and medical homeopaths were found to be very similar to those of traditional acupuncturists and traditional homeopaths: the legitimacy values presented in this chapter were also central (countervailing) values emphasised by CAM practitioners in Chapter Four.

A process of 'incorporation' (Saks, 1995a) or 'co-option' (Baer, 2001) of CAM by medical acupuncturists and medical homeopaths was also illustrated. However, the

findings presented in this chapter also suggest the importance of looking at the context, degree and level of such incorporation. Some structural constraints related to public healthcare contexts, such as time limitation of consultations and professional liability, seem to have prevented these doctors from adopting higher degrees of incorporation of CAM into their clinical practice. Furthermore, a consumerist and client-oriented approach attached to the decision of which medical system to use was evident. Some aspects of the 'conversion' scenario were also noticed to varying degrees. Four medical doctors from this research showed signs of being hybrid practitioners, using CAM and the biomedical paradigm interchangeably but 'moving [to a considerable extent] toward non-traditional approaches to health and medicine' (Goldstein et al., 1985:323). They were labelled as 'detached', as they detached their medical practice from the public service. In a sense, their predisposition to be 'holistic physicians' (Goldstein et al 1985, 1987, 1988), by detaching themselves from mainstream medical practice and careers and from traditional paths of healing, was apparent.

Overall, this illustrates the split within the medical profession, which has responded in a fragmentary rather than collective fashion, to camisation and to CAM practitioners' attempts to encroach upon healthcare in Portugal. Medical acupuncturists and medical homeopaths, by their very nature as medical doctors who had committed themselves to heterodox practices, seemed to contribute to a fragmentary and therefore postmodern healthcare. Nonetheless, the adoption of an incorporationist scenario of CAM was apparent at many levels. When all the accounts were analysed, it was clear that none of the eleven medical doctors had overtly converted to Chinese Medicine or a homeopathic ideology, despite presenting some degree of uncertainty, fluidity, and malleability in relation to which therapeutic philosophy they should adopt. At the conceptual level, even 'detached' doctors presented themselves as sheltering behind their profession and highlighted incorporationist ideas of CAM. Furthermore, although differing in the strategies employed, both those medical doctors not committed to CAM and those who embraced CAM showed a willingness to acquire control over camisation, by seeing themselves as the well-guarded bastions of health and therefore as the ones legitimised to validate CAM treatments and solutions to human problems.

Although Portuguese society has shown signs of a post-modern medical care, through the move of a faction of medical doctors towards the use of CAM in their clinical practice, it has also leaned on modernity, at least at the conceptual level and the level of

the professions, as medical acupuncturists and medical homeopaths showed willingness in preserving their privileged position as ‘medical doctors’ within the system of healthcare professions.

The scenario of CAM practice by the Portuguese medical profession has provoked enthusiasm among some medical doctors. In Portugal, like in many other Western countries, these professionals have provided themselves with CAM knowledge and CAM perspectives on healing within a public healthcare market that rejects traditional CAM practitioners. As the situation of statutory regulation of CAM has developed slowly, medical doctors have been able to assess the ‘heterodox challenge’ (Saks, 1992) and to protect their interests on behalf of their profession. Furthermore, the medical profession has been successful in influencing national health policy on CAM regulation. On the one hand, the public healthcare system in Portugal, which provides a home for the medical profession, has also been a host to acupuncture but not to traditional acupuncturists. Traditional acupuncturists therefore have been marginalised from the public health-service. Acupuncture is practised in the National Health Service by ‘multi-skilled’ medical doctors (Collyer, 2004), or reskilled doctors, who have acquired competency in medical acupuncture. Homeopathy, in turn, remains a rejected therapy within the medical establishment and has been banned from public healthcare.

On the other hand, the move of these medical doctors towards heterodox healing practices may have positioned them in a privileged place in the private healthcare market. The higher status medical doctors enjoy with the public (Cabral et al., 2002) may give them an advantage against CAM practitioners within private healthcare, as the latter have seen their statutory regulation postponed and have consequently achieved a lower professional authority. According to Wiese et al.’s (2010) models of CAM inclusion in mainstream healthcare in Western society, two different scenarios have apparently developed in Portugal: one where CAM has been selectively incorporated into public healthcare through the training of medical doctors in ‘selected’ CAM ‘techniques’; the other, often a private scenario and a ‘patient centred model’, ‘where the level of integration between [CAM and biomedical] systems is the choice of the healthcare consumer, allowing for the recognition of the differences of paradigm between biomedicine and CM [complementary medicine]’ (Wiese et al., 2010:329). Both scenarios, however, have entailed a fragmentation and a hybridisation of medical

practice and therefore ‘... have contributed to a more postmodern healthcare system’ (Frank and Stollberg, 2004:369).

This chapter has contributed to an analysis of the extent to which the relationship between CAM and the medical profession is changing in Portugal. These two actors have been generally analysed as homogeneous interest groups seeking occupational closure within the system of professions and within the healthcare market. It became apparent, however, as a result of the data analysis in this chapter that the medical profession has diverged internally. The discourse of a faction of medical doctors committed to CAM on CAM was often of an incorporationist nature, in contrast to other medical doctors (surgeons and GPs) holding more subordinate views of CAM. Moreover, the influence of the Portuguese Medical Council on the views of orthodox medical doctors not committed to CAM could not be found in the views of their colleagues who were committed to acupuncture and/or homeopathy. One reason for this is the fact that some of these medical doctors practised a CAM therapy, homeopathy, which remains rejected by the Portuguese Medical Council. Therefore, their discourses have sometimes clashed with the institutional medical approach towards CAM. The aim of the next chapter is therefore to shed some light on the intra-occupational fragmentation within the medical profession and CAM in Portugal, and to analyse the extent to which CAM and the medical profession have been cohesive in their relationship.

CHAPTER NINE

INTRA-OCCUPATIONAL FRAGMENTATION

WITHIN THE MEDICAL PROFESSION AND CAM

9.1. Introduction

The current relationship between CAM and the medical profession in Portugal and the role of the State and other corporate parties such as the pharmaceutical industry in that relationship have been the focus of this study's analysis so far. As a result, the previous chapters have been concerned with inter-group dynamics. In this chapter we focus on intra-occupational issues. The degree of internal cohesion amongst representatives of the medical profession and of CAM regarding CAM recognition by Portuguese mainstream healthcare will be examined.

As previously discussed, Abbott (1986, 1988) alerts us to the fact that professions are usually internally heterogeneous and stratified groups. For example, within the medical profession the medical elite is usually personified by the national Medical Council. There is also the stratified medical body made of rank-and-file medical doctors committed to different specialities, with different backgrounds, different worldviews and different levels of relationship with other healthcare professionals. Hirschhorn (2006), for example, brings into light the fact that the medical profession is made up of different parts which sometimes are contradictory or loosely connected by knowledge and practice ideologies. Saks (1998), in turn, has reiterated that although orthodox biomedicine has an ideological coherence, it has witnessed a complex division of labour, with the expanding number of health professions and specialities being a good example of this trend. Original concepts such as 'deviant insiders' (Dew, 2000), 'medical heretics' (Wolpe, 1990) or 'dissenters' (Goldstein et al., 1987), have been used to describe those medical practitioners who committed the 'error' of practising one or another form of CAM. They present attempts to conceptualise a new professionalising faction arising from within the medical profession that has challenged the medical orthodoxy.

In relation to CAM, previous research (Baer, 2006; Gilmour et al., 2002; Gort and Coburn, 1988; Wahlberg, 2007) has shown the pluralistic and sometimes diverging methods used by CAM practitioners to stake their claims. Baer (2006), for instance, has shown that one of the factors preventing CAM practitioners from achieving statutory

regulation in most Australian states has been the multiplication of CAM associations and colleges. As Baer (2006:1776-1777) stated, the leaders of these associations and schools are usually 'strong-willed and charismatic individuals who reflect both the laissez-faire mentality of complementary medicine and its difficulty in presenting a unified front to the larger society, particularly the State'. Baer (2006) also showed how the drive of naturopathy towards State regulation in Australia has divided the Australian naturopathic community into those who abide by the restrictions imposed by the State and those who seem to be against statutory regulation and the subsequent scientific orientation of naturopathy. Also, Gort and Coburn (1988:1068), in their study on the changing relationship between naturopathy, medicine, the State and chiropractic in Canada, highlighted the existence of intra-occupational conflict within CAM in the 1980s. Baer (2006) also showed how Australian naturopathy initially became intertwined with both chiropractic and osteopathy; and Saks (1998) pointed out the fragmented nature of CAM in Britain by showing that while homeopaths, for instance, have become strongly organised, practitioners from other fields such as reflexology have worked on a more individualised basis.

In summary, as Dew (2000) has suggested, it would be more appropriate to talk about a variety of voices and a plurality of positions within the medical profession and the CAM field. This is in line with the postmodern condition of current Western societies which emphasises difference, multiplicity and fragmentation within occupations. Scholars who study CAM (e.g. Saks, 1998) have claimed that the development of CAM has enhanced a spectrum of discourses in the health arena and has thus contributed to a postmodern society with an eclectic approach to health. Yet Saks (1998) also alerts us to the fact that the current fragmentation associated with the expansion of CAM may not necessarily mean a transition to postmodernity.

In this chapter the analysis of the internal divisions within the medical profession and CAM regarding CAM recognition in Portugal will be presented. The following research question will be addressed: To what extent has the interplay between the medical profession and CAM practitioners in Portugal been consensual? For example, to what extent have medical doctors drawn on their institutional body's views on CAM? How have medical acupuncturists and medical homeopaths defined themselves in relation to more orthodox colleagues' medical doctors? Furthermore, to what extent have acupuncturists attempted to demarcate the boundary between themselves and

homeopaths? Finally, to what extent have acupuncturists and homeopaths been consensual among themselves?

In order to answer these questions, the chapter is divided into two main sections: (1) the first section analyses intra-occupational issues within the medical profession, paying particular attention to the accounts of the 21 medical doctors about their regulatory body and on their profession; (2) the second section addresses intra-occupational issues within CAM; then strategies of demarcation used by acupuncturists in relation to homeopaths, both at the biomedical and the traditional levels of practice (in total n=31), will be addressed; finally, the diverging ways used by acupuncturists and homeopaths to claim for legitimacy in healthcare will be explored.

9.2. Fragmentation within the Medical Profession

Within the debate over CAM recognition in Portugal, the notion that the medical profession is a homogenous entity is a contested one. The discourse of the medical doctors seemed to change according to their position within their profession. For example, a common site of contention has been the relationship between rank-and-file medical doctors and their regulatory body, the Portuguese Medical Council (PMC). In order to fully explicate the controversial aspects of this relationship, the following section is divided into two parts: (1) the analysis of the complaints expressed by medical doctors about their regulatory body the PMC, and their profession; (2) the analysis of the rhetoric of medical doctors who supported the PMC.

Complaining about the PMC and the Profession

The data analysis suggested a great deal of tension between the individual medical doctors and their institutional body. Not surprisingly, those medical doctors who have committed themselves to practising homeopathy seemed to be particularly critical of their regulatory body. One of the medical doctors, an accredited medical acupuncturist and medical homeopathic leader, expressed feelings of regret and sadness for belonging to the Medical Council, as the following quotation illustrates:

I: The Medical Council ... I was about to take them to European Court, as I said before. Because I'd have enough evidence to condemn them. But I didn't as I'm more interested in conquering than in destroying. Because I'd destroy most [of the Council]. Because the Medical Council is compromised. It's a shame, a sadness.

I'm ashamed of belonging to the Medical Council. I mean, I fight for a change. Because we need to fight for what we believe in.

JA: How is [the Medical Council] compromised?

I: It's too ostentatious, too many values ... because *conventional medicine is outdated*. I've got so much evidence of that. (I27: MA, MH, my emphasis)

Another non-accredited acupuncturist and medical homeopathic leader compared the Council to a 'bunker' and linked it to economic interests. His training and credentials for practising acupuncture had been acquired outside the biomedical arena. He applied to acquire competency in 'medical acupuncture' accredited by the PMC through an equivalence of courses. He asserted that his application was rejected because the training he acquired in this therapy seemed to be designed for lay acupuncturists rather than for medical acupuncturists and therefore does not reach the Medical Council's standards:

For me the Medical Council ... this is an example ... they set up this training for accreditation in [medical] acupuncture. I did it [the training in acupuncture] in a different place. Why don't they want to give it [the competency in medical acupuncture] to me? Perhaps because I didn't give them the money, right. They want me to do the course again? I've already spent a lot of money on another course! This is an example. And I'm a doctor and they've caused these silly quarrels. ... That's why I said ... the Medical Council for me is like a bunker. It's the elite, let's say. They're not open-minded ... (I32: MA, MH)

This respondent unveiled the tension and the conflict of interests between the rank-and-file and the elite levels of the medical profession. He also disclosed the power of the medical elite in deciding the type of credentials medical doctors must have to be recognised as 'medical acupuncturists' in the country.

A common concern expressed by medical doctors committed to homeopathy centred on their apprehension about being involved with a therapy forbidden by the Council. For example, a medical homeopath showed her discomfort in disclosing her homeopathic training as it would cause potential problems with the PMC and her subsequent deregistration from it:

I've got training in homeopathy. I've never put it in my CV as I'd be expelled from the Medical Council, yet I've had training in homeopathy for a long time. So, I'm a fellow member of the Royal London Homeopathic Hospital⁴⁵, but in

⁴⁵ Now renamed *Royal London Hospital for Integrated Medicine*.

fact I've never written this down [in my CV] as I'd be, as I said, expelled from the Medical Council. Presently [the scenario of] homeopathy has changed [in the country], it can be found in every pharmacy, even if the Medical Council doesn't accept it but it's obvious that someone needs to practise it. (I31: MH)

Another accredited medical acupuncturist who was also a medical homeopath described himself and his fellow medical homeopaths as 'rule breakers', a variation of what Dew (2000) has called 'deviant insiders', i.e. medical doctors who committed the 'error' of taking up heterodox practices and are associated with traits such as fraudulence by their peers:

And so we [*medical doctors who practise CAM*] are *rule breakers*, as you can imagine. What's the matter with being a rule breaker? It's that the rule breaker ... cannot make mistakes. If they make mistakes everyone will attack them. I mean, a conventional doctor can accidentally kill, by negligence or as a consequence of iatrogenic effects, can kill one, two, three, four, five persons a day. As you may know, around 30% or even more of the deaths or [medical] accidents in hospitals are the result of side-effects of the therapeutic in use. So, we [medical homeopaths] aren't guilty of that *iatrogenesis*. This stinks to high heaven. (I30: MA, MH, my emphasis)

This interesting quotation shows how this medical doctor used arguments which criticised his own profession to legitimise 'medical homeopathy'. As Wolpe (1990) has shown, emphasising the failures of their own profession is a typical strategy used by 'medical heretics', i.e. medical doctors who use heterodox therapies, to respond to their peers. In this research, the emphasis given to dehumanisation, over-specialisation, over-medication, the economic interests of pharmaceutical laboratories, body/mind disintegration and iatrogenic conditions of modern medicine were common features of much of the discourse of these 'rule breakers'. For example, this respondent's whole discourse was marked by bringing attention to the benefits of homeopathic treatments over certain diseases such as hepatitis and malaria and by showing the unsuccessful attempts of modern medicine in curing these same illnesses. The following statement shows the status given by him to homeopathy as an efficient therapy to treat hepatitis and shows his orthodox colleagues' reactions to his 'deviant practice':

A few days ago a doctor told me 'look, we have a new therapy ...' it wasn't homeopathy, was another one ... '... which causes the seroconversion⁴⁶ of hepatitis B and C in eight months. That's funny. But hepatitis' seroconversions are also possible in six months. And amazingly, we [he and his fellow medical homeopaths] cause seroconversions with homeopathy in three weeks. And there

⁴⁶ The production of antibodies in the blood to clear, in this case, the Hepatitis virus.

are still people tragically dying with hepatitis. But this is not only with people. One day [a friend of mine] had a dog with hepatitis, and on the phone ... he went to the vet ... 'look, the dog is gonna die. There's no chance, everything is out of control, the hepatitis tests and so on ...' The dog wasn't young though. ... And then I prescribed her [the female dog] a homeopathic remedy ... 'look, give this to her as at the end of the day she is gonna die'. She [the dog] was given the medication and after a week she was absolutely fine. He went [with the dog] to the vet again, explained to her what happened, she got interested, asked him for my contact details ... she didn't call me. Moreover, all my colleagues who are interested [in homeopathy] and have seen the [homeopathic] results in patients, they ask for my contact number as my phone is always available. [Available] for the doctors, for you, for the patients ... I'm always available. And they never contact me. (I30: MA, MH)

This extended account shows how this medical homeopath attempted to legitimise homeopathy by highlighting its quicker effect in the treatment of hepatitis, when compared to other 'more orthodox' procedures. His discourse underlined the idea that homeopathy has been undervalued and has been used as a last resort measure in situations for which biomedical treatments are no longer suitable. He reported the reservations of more orthodox medical doctors to their 'deviant' colleagues who, as Dew (2000) has suggested, have embraced deviance or 'abnormal' behaviour and have practised deviant acts which, despite causing curiosity, are not legitimised as the norm and end up being undervalued by the medical community. He also attempted to maintain his availability for his colleagues who 'have voted for silence' in relation to his involvement with homeopathy. As with holistic physicians in Goldstein's research (1987) in the USA, feelings of marginality in this medical acupuncturist and medical homeopath were identified. According to Goldstein (1987:117), this may be due to a sense of '... belonging to a low-status specialty group'. Another accredited medical acupuncturist and medical homeopath reinforced this idea, arguing that:

A conventional doctor is programmed, is limited and bounded by the conventional scientific knowledge and cannot move away from that. They can move but with punishment and persecution. (I27: MA, MH)

A few 'rule breakers' disclosed their personal experiences and fears of medical prosecution. This same medical homeopath, for instance, who left the public health system and went into private practice, disclosed his own problems with the PMC:

I mean, I was persecuted in the sense that the Medical Council sent some people to investigate if I was making financial profits [from homeopathy], but we know very well that conventional medicine and, let's say, the medical doctors, they

receive, or used to receive ... I don't know how things are at the moment ... when I was working [in the public healthcare system] ... I don't know a sole doctor who hadn't got [financial profits]. ... Financial profits given by the [pharmaceutical] laboratories. (I27: MA, MH)

The insinuation of a profit-oriented relationship between the medical doctors and the pharmaceutical laboratories is apparent in this last statement. This is in line with previous research (Busfield, 2010; Elliott, 2004; Van der Geest and Whyte, 1989) on the strategies used by pharmaceutical companies when expanding demand for their products amongst medical doctors. Busfield (2010:936) for instance, insists that one such strategy has been the promotion of branded products to medical doctors' act of prescribing, through '... familiar incentives such as providing pens, mugs and post-its, and sponsoring conferences'.

Another 'rule breaker', a medical doctor who embraced homeopathy, disclosed the structural demands of the profession of medicine which forced him to act under the 'gaze' of the Medical Council and thus perpetuated a disenchantment with medical practice based on guidelines and prescriptions. His account below shows how he felt about practising the profession of medicine:

Practising medicine is a delusion. We don't work like we want ... we are too constrained. It's very boring. ... How many times did I prescribe stuff that I'd never give to my kids? But from an ethical point of view or from the Medical Council's point of view they are the right prescriptions. But they are stuff that I'd never give to my kids, in those circumstances. And we have to do that everyday, right, so at the end of the day we are not free ... we don't feel free. (I29: MH)

The 'medical heretics' also capitalised on themes and 'linguistic constructs' which, as Wolpe (1990:915) put it, 'are secondary, minor or background themes in the orthodoxy and elevates them to positions of primary importance'. For example, the emphasis on Quantum Physics and on themes such as 'energy', 'love' and 'belief' is evident in the following statement provided by an accredited medical acupuncturist and medical homeopath:

My dream, as I say, is to change the curriculum of [conventional] medical schools, to adapt them to modern science, because we are still based on a science ... I wouldn't say outdated ... the Newtonian science is outdated, because *quantum physics* has opened new doors ... and so, we need to be open-minded and to include the [concept of] *energy* ... because doctors are afraid of talking about *energy*, they are afraid of talking about *love* in the consultation which is

fundamental. A doctor cannot get good results, a good relationship, if they don't have the capacity to *love*. (I27: MA, MH, my emphasis)

This respondent raised the point of adapting the curriculum of medical schools to a 'changing medical science' which builds on more patient-centred and holistic attitudes. He criticised modern medicine and medical doctors for having neglected important themes in their discourse. This type of attack on modern medicine from those medical doctors involved with CAM was described by Wolpe (1990) as a 'heretical ideology'. For instance, by emphasising themes which have been relegated to a minor status by biomedical science, this respondent attempted to challenge the medical orthodoxy and its entrenched medical ideology. He also raised the point of competition between himself and his more orthodox colleagues such as the surgeons. When referring to the good results of homeopathy in treating sore throats, he disclosed that surgeons 'get angry as they get less surgery to do. They get angry.' (I27: MA, MH). At the level of the practitioner, this may illustrate the fact that medical homeopaths saw themselves as competitors in relation to their more 'trustworthy' colleagues the medical doctors. They acknowledged that they could poach jurisdictional areas long occupied by other medical specialists and that this could challenge the existing order within healthcare. At the level of knowledge, this also suggests that homeopathy was seen, although to different degrees, as an alternative to 'normative medical practice' in many situations.

Most of the medical doctors, including the ones uncommitted to CAM, also thought of the Medical Council as an 'elite' institution which exerts control over medical knowledge:

Our [Medical] Council isn't open enough. Even within the Council there is no debate. The Council's opinions ... normally are only debated by a few [medical doctors], as there is no mobilisation, the people aren't interested enough, our country doesn't have the habit of debating things, we don't care about the debate, people don't get involved either themselves or through others. (I44: surgeon)

This account contrasts the Council, personified as the 'medical elite', with its members' rank-and-file medical doctors and suggests the existence of factions within the Council which have monopolised the Council's views. The existence of 'elites' within the medical profession is reiterated by Hafferty and Light (1995), who pointed out that it often results in '... a growing tension between the knowledge generators and the knowledge consumers, the rule setters and rule followers, the managers and those being

managed, and those who function as owners versus those who perform as employees' (Hafferty and Light, 1995:139). For example, a surgeon described the PMC as an 'acephalous' institution and asserted vigorously that his opinions regarding priorities within healthcare professions were not shared by the Council:

I'll give you an example of a small profession which is a very interesting paramedic group, the podiatrists. The podiatrists are people who *study four years*, foot troubles, foot health, etc. The diabetic foot is something endemic in Portugal. It's something worrying, we are in a very underdeveloped country with thousands of amputations a month, and so there are many people who are badly treated in a country that doesn't care about their [citizens'] feet. And the foot is essential in human life. We still haven't got podiatrists in hospitals. ... Another example ... At a time where obesity is also endemic, we need nutritionists. And we haven't got them in the hospital setting either. ... And so we now have the regulation of occupations that *I hope won't get into the hospital setting before others [occupations]*. If somebody tells me that we'll have a naturopath treating patients in the hospital I'll get sad, you know. (I35: surgeon, my emphasis)

This extended statement shows how this surgeon perceived CAM demands to be integrated within mainstream healthcare in a negative way. The respondent supported healthcare professionals like podiatrists and nutritionists who he emphasised have already acquired institutional and standardised training. He saw CAM therapies as 'non-essential' and was the only one who overtly did not agree with the Council's support of CAM. He envisaged CAM professions as remaining outside the public healthcare system and as working in the private sector, a shared vision among all the respondents.

Another orthodox medical doctor committed to medicine as a GP, although distanced from CAM and CAM demands, described the Council as a site of resistance to CAM in general:

To be honest I don't know very well the Council's position on that matter [CAM recognition] but I believe that there is still a total rejection to help, frame or even understand the ways these alternative or complementary therapies can be integrated into the healthcare system. (I38: GP)

So, as one can see, the PMC's interests often did not match the interests of rank-and-file medical doctors. A gap seemed to exist between the structural and the individual level of medical practice. Although there are medical doctors practising homeopathy, the PMC does not legitimise this practice. The medical homeopaths, perhaps because they have seen their choices marginalised and forbidden by the PMC, tended to attack their

regulatory body. Orthodox medical doctors uncommitted to CAM were rarely uncritical of the PMC and often highlighted the existence of a medical elite as well as the hierarchical nature of the medical power. Also, a considerable level of detachment of rank-and-file medical doctors from the PMC's decisions and positions was often disclosed. Such a gap was frequently justified through accounts of the Council as an enclosed space which was of difficult access and did not promote the involvement of grassroots medical practitioners. Finally, among medical doctors, there were some 'heretical groups' (Wolpe, 1990) who have challenged medical orthodoxy and have used their own strategies to maintain their '... privileged position from which to dispute the orthodox ideology' (Wolpe, 1990:914). We will now analyse the rhetoric of those medical doctors who seemed to be supporters of the PMC.

Supporting the PMC

As has been previously mentioned, acupuncture is the only CAM therapy to be regulated by the PMC and thus accepted as a medical competency, and this has been the case since 2002. It is therefore not surprising that those medical doctors who are committed exclusively to medical acupuncture or have elected acupuncture as their CAM therapy seemed particularly supportive of the Medical Council and emphasised its role in helping to standardise and solidify 'medical acupuncture' in the country. For example, one accredited medical acupuncturist claimed the role of the Council in drawing CAM limits between medical and traditional acupuncturists:

JA: Is it difficult to draw the line between the medical doctor and the CAM practitioner?

I: We must seek the support and cooperation of the Medical Council. I'm sorry but it should be like this. The Council has its own ethics and can draw boundaries. They [the Council] may not be very pleasant to [CAM] practitioners and to the training schools of acupuncture, but that is a question of ... I accept practitioners of acupuncture [traditional acupuncturists], but I don't accept doctors of acupuncture trained by a non-medical school. (I24: MA)

According to this respondent, medical acupuncturists should have a 'deviant insider' practice, as they are deviant because they embrace heterodoxy but they still practise inside orthodox medicine. Therefore, they must subordinate themselves to the Council's guidelines for the practice of medical acupuncture. Dew (2000) suggested the same idea among medical acupuncturists in New Zealand, who have seen their acupuncture practice translated into guidelines and protocols that should be followed if they want to

remain inside the medical orthodoxy. And Wolpe (1990) aptly stated that the ‘heretics’, or those who challenge the [medical] orthodoxy from inside [medical acupuncturists and medical homeopaths], are themselves committed to a [biomedical] ideology and discourse that they should preserve if they want to maintain their privileged position within orthodoxy.

Another medical acupuncturist leader who was involved in the training of medical doctors in acupuncture emphasised the status achieved by ‘medical acupuncture’ in the country and used credentials accredited by the Council to legitimise medical acupuncture and medical acupuncturists:

JA: How do you see the relationship between medically and non-medically trained acupuncturists?

I: I’ve never tried hard to think about that because ... I mean, I think that the two are not related. ... Each person knows about their own training. We [medical doctors] have a degree in medicine, a specialty and now we have a competency in [medical] acupuncture accredited by the Medical Council. I think we can’t .. What do you want me to say? To compare them [medical acupuncturists with traditional acupuncturists]? I cannot have a professional relationship with one of those individuals [traditional acupuncturists] (I26: MA)

This last statement shows a clear attempt by a medical acupuncturist to demarcate herself from traditional acupuncturists by using the Medical Council as a powerful source of legitimacy of medical acupuncturists in the country. To summarise, medical acupuncturists’ claims about the need for the intervention of the PMC to protect medical acupuncture and medical acupuncturists in the country were clear. Furthermore, the PMC’s support of medical acupuncture was used as a way to legitimise medical acupuncturists and to demarcate them from traditional acupuncturists. We will now address the issue of intra-occupational pluralism within CAM.

9.3. Fragmentation within CAM

The analysis presented in this study has also suggested that there is a certain degree of pluralism within CAM. For example, medical and traditional acupuncturists seemed to want to demarcate themselves from medical and traditional homeopaths respectively. Furthermore, among medical and traditional acupuncturists and medical and traditional homeopaths themselves, divisions were apparent when they considered which type of acupuncture and homeopathic treatment was most appropriate. We will first see how

medical and traditional acupuncturists attempted to demarcate themselves from medical and traditional homeopaths. Secondly, we will analyse divergent representations of acupuncture and homeopathy presented by medical and traditional acupuncturists and medical and traditional homeopaths respectively. Finally, the conflicts within acupuncture and homeopathy in terms of schools, training and curriculum will be considered.

Demarcating Acupuncture from Homeopathy

Despite the small number of medical doctors in this study committed exclusively to acupuncture (three out of twenty one), it is still of interest to reflect on the way they portrayed homeopathy. All three of these medical acupuncturists considered homeopathy's lack of scientific evidence as its main legitimacy problem. For instance, one accredited medical acupuncturist leader compared acupuncture and homeopathy in the following way:

They [the researchers] give a placebo remedy and then a homeopathic remedy and they get most of the time positive results I think. Or they get positive results in many cases let's say. But how does it work then? As far as I know, and you can ask [medical homeopaths] this, it's not that easy to explain [how homeopathy works]. And nowadays with acupuncture *we already know how it works and we can validate its results*. ... You can ask my colleagues 'so, how does it [homeopathy] work? Do you know?' I don't think they know that clearly. (I25: MA, my emphasis)

This quotation is interesting as it shows how this medical acupuncturist felt that it was necessary to draw boundaries between acupuncture and homeopathy by using the scientific validation argument. He claimed that homeopathy cannot scientifically validate its results unlike acupuncture and made a distinction between these two therapies based on the 'scientificity' of acupuncture. This attempt of 'purifying' acupuncture by mainstreaming it in healthcare delivery and by detaching it from CAM epistemology was typical of these three medical acupuncturists. In the same vein, another accredited medical acupuncturist gave an incorporationist account of acupuncture and attempted to demarcate acupuncture from homeopathy by presenting the former as a drugless neurophysiological technique and the latter as a drug therapy which can overlap and clash with orthodox medicine:

Acupuncture, because it is used for pain mainly in terminally ill patients, which is a very sensitive area, because pain ... people don't like being in pain and the

terminally ill, mainly cancer patients, at an analgesic level, we can only control [pain] with morphine and sometimes badly ... so acupuncture ... it has an undoubted place [in medicine]. With the advantage of, because it's not a remedy or a drug, it doesn't compete with the pharmaceutical industry. While in the case of homeopathy it's different. (I27: MA, MH)

It is clear in this last statement that homeopathy, in contrast to acupuncture, was considered to pose a challenge to other major stakeholders such as the pharmaceutical industry. In contrast, a medical homeopathic leader placed acupuncture a long way from conventional medicine, while situating homeopathy as very close to conventional treatments and emphasised economic reasons for the institutional rejection of homeopathy:

I think that acupuncture is something very distant from conventional therapies. Homeopathy [in turn] is very close to conventional therapies. There are [homeopathic] remedies which are administered and perhaps they are afraid that those remedies invade ... because, for instance, if all of a sudden the paediatricians started using homeopathic products, it would be many tons of antibiotics, many tons of antistaminics, many tons of anti-inflammatories which wouldn't be sold anymore. So, I think that the opposition isn't a scientific opposition. It's an economic opposition. It has to do with numbers. And not with the [argument about] homeopathic dilutions which says 'oh that is so diluted that it doesn't have anything [the biologically active substance] inside anymore'. Who can tell you that there is nothing there? We already know that in our organism the cytokines [molecules] work in infinitesimal doses and some hormones work in doses ... (I29: MH)

This respondent presented homeopathy as a potential challenge to biomedicine and pointed to the conflict of interest in legitimising homeopathy. According to him, the relationship between the medical profession and corporate actors such as the pharmaceutical industry could be undermined if a low-cost homeopathic medication was adopted in place of conventional chemical medication in the form of antibiotics, anti-inflammatories and antistaminic drugs.

The attempt to demarcate acupuncture from homeopathy was clearer among traditional acupuncturists. A few traditional acupuncturists reinforced their claims about acupuncture by picturing this therapy as opposed to homeopathy. For example, one of the traditional acupuncturists showed resistance to acupuncture's absorption into the medical profession and pointed out the following:

So, the [Chinese Medicine's] diagnosis, unlike for instance homeopathic diagnosis which is very much like Western medicine [diagnosis] ... Chinese medicine's diagnosis absolutely doesn't have anything to do [with homeopathic and Western medicine's diagnosis] and it's very hard to achieve. (I2: TA)

This quotation evidences, once again, an attempt to draw a clear boundary around acupuncture's identity by showing its distinctive mode of achieving a diagnosis, as opposed to the biomedical or homeopathic mode. He referred to an overlap between homeopathy (and some other CAM therapies such as naturopathy) and orthodox medicine and used the following argument to legitimise and demarcate acupuncture from homeopathy:

As I say, I don't know very well the others [CAM therapies] ... I know that *homeopathies*, naturopathy, all of them ... and I should say again that I don't know them very well, but it's my opinion ... but I really think that they overlap [with Western medicine]. But even so I don't think they are incompatible. They usually share the same stance, the same diagnosis, and then they apply different treatments. ... What changes here is essentially the treatment. They've got things in common and so I believe that there's a bit of an overlap. But concerning what we [acupuncturists] do, I cannot really see the point [of not being accepted by the medical orthodoxy]. (I2: TA, my emphasis)

This respondent's use of the plural 'homeopathies' is deprecatory and is interesting in showing the line he tried to draw between acupuncture and all the 'other' therapies from which he distanced himself.

Another traditional acupuncturist admitted that homeopathy in Portugal does not seem to have adequate training to prepare future professionals. When asked about the reasons why the State is regulating six very specific CAM therapies rather than any others, he made the following comment:

Even if homeopathy in this country ... I don't know the sort of training on homeopathy in this country. I'm not sure if it's good enough to qualify people. (I4: TA)

This same respondent, when asked later why the PMC has accepted acupuncture but not homeopathy, disclosed that:

May be because it [homeopathy] lacks scientific evidence. Because as we know homeopathy is made of nothing, right. They [homeopathic remedies] are tiny

drops of alcohol... there is no physical matter there, right. So, how can that [homeopathy] have an effect in the body? (I4: TA)

This last statement is interesting in showing the disbelief in homeopathy of a CAM insider, i.e. a traditional acupuncturist with a holistic training in acupuncture. It exemplifies the lack of ‘group cohesion’ (Kelner et al., 2006) and a collective CAM identity, an aspect that greatly legitimises the debates around the meaning of ‘CAM’ as ‘... a somewhat clumsy (but nevertheless useful) meta-category that helps us impose meanings on practices that are hugely diverse and often paradigmatically disparate’ (Broom and Tovey, 2008:4). Gort and Coburn (1988) had already alerted us in the late 1980s to the changing relationship between naturopathy and chiropractic in the Canadian society. As they said (1988), chiropractic first cooperated with naturopathy but later jeopardised it, as it was presented as a competitor. They (Gort and Coburn, 1988:1070) aptly stated that chiropractors, after acquiring statutory regulation and consequently reducing their scope of practice, desired ‘... to put as much distance as possible between their newly legitimate ‘medical speciality’ of chiropractic and the still illegitimate and “quackish” naturopathy’. Although acupuncture and homeopathy in Portugal are not as intertwined as chiropractic and naturopathy are in Canada, one can state that attempts to purify acupuncture and to turn it into a ‘medical competency’ distinct from the still banned homeopathy have happened. We will now turn to an analysis of the diverging representations of acupuncture and homeopathy amongst acupuncturists and homeopaths.

Diverging Representations of Acupuncture and Homeopathy

Representations of acupuncture and homeopathy convey the way medical and traditional acupuncturists and homeopaths seemed to understand these therapies. This study investigated different representations of acupuncture and homeopathy among traditional and medical acupuncturists and traditional and medical homeopaths. For example, divisions can be found among traditional acupuncturists concerning the way they authenticated acupuncture. In particular, they differed over whether acupuncture means a stimulation of the *qi* (energy) or of the nervous system. A few traditional acupuncturists disclosed that they preferred scientific explanations of this therapy, while others presented more holistic ways of understanding acupuncture’s procedures. The following traditional acupuncturist explained his scientific approach to this therapy in the following way:

My approach to acupuncture draws on the American school [approach]. It has to do with physiology a lot. It has very little to do with esoteric energies. I have no need ... I'm not condemning those [other traditional acupuncturists] who follow that [esoteric approach]. Because usually we reach the same outcome. This is just a matter of approaching a pathology differently. Hmm ... I have no need to think that the *qi* is an energy which we get from the air and vibrates in the needle and gets into it and that's it. Perhaps it may be like this, I don't know. ... But I have no need to look at this in that way. I can better understand it [acupuncture] if I stimulate certain [pressure] points from the nervous system so I can stimulate certain organs' functions in our body. (I2: TA)

This quotation shows very well the 'scientific' worldview (Boon, 1998) adopted by this respondent, who is more likely to emphasise treatment at a physical level rather than at a mental or spiritual level. Later he disclosed, in the same scientific vein, that drawing limits about what an acupuncturist can treat is essential and stressed the need to be responsible about the limits of the acupuncturist:

So, it's a question of awareness and responsibility mainly. But as I say, many times people fail in getting that awareness because they turn all of this into a more ... energetic and esoteric stance. And then they think they can treat everything. And that can be dangerous. (I2: TA)

Although most of the traditional acupuncturists recognised the importance of an awareness of their limits, acupuncture's limits seemed very difficult to define, as one of the traditional acupuncturists declared: 'the limits of acupuncture are the limits of the acupuncturist' (I5: TA). This very pragmatic viewpoint clearly highlights a traditional view of acupuncture based on the importance given to the charismatic traits of the practitioner.

Different interpretations of acupuncture yield diverging forms of acupuncture treatment. According to one traditional acupuncturist, there are two types of acupuncture: 'symptomatic acupuncture', which is usually practised by medical doctors but also by some traditional acupuncturists, and tends to be based on guidelines and protocols; and 'traditional' or 'classical' acupuncture, which tends to be more 'intuitive' and 'holistic':

Look, a *symptomatic acupuncturist* has training which might be long, but *they get used to treat with protocols*. That is, if there's someone with an allergy, a *renitis*, a discal hernia, they'll give a prescription. They [the symptomatic acupuncturists] will needle this, this and that [specific acupuncture pressure points]. ... The symptomatic [acupuncture] deals with protocols and examines the illness or the person by concerning only with the symptoms. ... *Non symptomatic medicine*, which is the Traditional Chinese Medicine ... this is where I've got training and

we don't have any sort of previous treatment plan. So, we must listen to the person, we must know who they are, the environment where they live, and then we decide for the treatment every single day. And the treatment never is the same. (I5: TA, my emphasis)

This same respondent reinforced a clear position of demarcation from other acupuncturists who do not acquire the 'right' training and end with superficial acupuncture knowledge:

One day at school one of the students had migraine ... and then he [the teacher] needled an [acupuncture pressure] point and she [the student] told me 'do you believe that last week a teacher needled this [acupuncture] point to treat my migraines and I got worse?' And I asked her: 'how long did the needle stay there for?' 'Oh...' she said, 'around 20 minutes'. And I said: 'Of course you could only get worse'. Because it's such an important [pressure] point to use in migraines, but when we use it ... it should be a quick needling. No more than two, three minutes. This is an example. So, that happens. *When someone gets basic acupuncture training*, perhaps they [the schools] don't teach them [the students] this [such detailed aspects about needling]. (I5: TA, my emphasis)

Diverging interpretations and administration of treatments were also greatly present within homeopathy. During the history of this therapy, many internal divisions occurred in what concerns, for example, the distinction between classical homeopathy, or the one propounded by Hahnemann, and 'complex' homeopathy. 'Complex' homeopathy draws upon the selection of different homeopathic remedies which, when combined together, generate a 'complex homeopathic preparation' for symptomatic treatments. 'Unicist homeopathy', in turn, is based on a single application of a single remedy on the basis of a diagnosis reached through detailed story-telling by the patient. While the complexist approach appears to be more pragmatic and more physiologically oriented, the 'unicist' or 'classical' approach is generally seen as more psychosocial and patient-oriented. The following account from a traditional homeopathic leader involved in homeopathic education in the country gives an interesting illustration of the divisions within homeopathy about the way homeopathic treatments should be administered. The participant suggested two diverging views of homeopathy, the 'unicist' and the 'complexist':

I think that homeopathy is a science. If the professionals [traditional homeopaths] are prepared [to practise it], I've got some doubts there. ... Homeopathy in Portugal was always very associated with naturology, or reliant on naturology, and in Portugal the [homeopathic products] market was always very successful... when I say homeopathic products I'm talking about complex homeopathic

[preparations]. So, complex homeopathic [preparations] are of course homeopathic products but for me, and this is the first critique, this is not the *authentic homeopathy* [my emphasis]. For me this is *allopathisation of homeopathy*. ... My philosophical, therapeutic, doctrinal, clinical perspective is not this one. And I have fought for a long time for a change and have supported another perspective totally different from this complexist perspective of homeopathy. (I17: TH, my emphasis)

This traditional homeopath contrasted ‘complex’ homeopathy to ‘unicist’, ‘classical’ or ‘purist’ homeopathy. Like this traditional homeopath, a few others referred to complex homeopathy as a form of ‘allopathising’, commercialising and accommodating homeopathy to the conventional healthcare market. The last respondent referred to the commercial targets of complex homeopathy and to its market-oriented philosophy. He defined himself as a ‘unicist homeopath’ and attempted to legitimise ‘unicist’ homeopathy through appeals to its origins and historical roots:

Homeopathy is above all a therapeutic system which emphasises the [idea of] individuality ... Every single person is a unique entity, and so we should have a homeopathic remedy which covers the maximum number of symptoms or at least the main ones from that individuality. This is one of the homeopathic principles claimed by Hahnemann. (I17: TH)

This respondent attempted to legitimise the ‘unicist’ approach to homeopathy as the ‘authentic’ one by appealing to the idiosyncrasies of the patient and the foundational ideology of this therapy. Degele (2005) in her study of homeopathy in Germany, reported similar findings by showing that administering ‘singular remedies’ (unicist homeopathy) rather than ‘combinations of drugs’ (complex homeopathy) was a main demarcation criterion for being considered an ‘authentic’ homeopath. Some traditional homeopaths commented that complex homeopathy dominates homeopathic practice in Portugal. An interesting reason given for that was that complex homeopathy renders the process of treatment less complicated as it usually targets a larger number of patients which makes it more profitable for the pharmaceutical industry:

There is [also] the commercial point of view. If you go to a natural health products shop to buy a [homeopathic] product, perhaps it will cost you forty or fifty euro, the complex [homeopathic preparation]. If you go to the pharmacy and buy some granules prescribed by the unicist [homeopath], a tube [of granules] of eighty grams will cost you four euro and forty cents. Of course there is a commercial aspect to this because the other practitioner perhaps has a deal with the shop or with a specific laboratory to sell a specific product and so this increases the cost of the product ... (I20: TH)

From the point of view of this traditional homeopath, the complexist homeopathic market has devalued 'authentic' classical homeopathy. This respondent linked complex homeopathy to a process of the 'marketisation' of CAM (Collyer, 2004), in this case in Portugal. Also, she pointed to the fact that homeopathy has turned into a profitable industry and has strategically allied itself to pharmaceutical laboratories in order to maximise profits. This same traditional homeopath described in a very clear way the place of 'unicist' and 'complex' homeopathy in the market and tried to delegitimise complex homeopathy by emphasising its side effects:

[Complexist homeopathy] is the one that perhaps nobody recommended to you but you go to a natural health products shop and someone there recommends it to you. ... If you got the flu, for example, [the employee] will give you a product which is the result of a mixture of different substances which will cover a vast number of your symptoms but they may not cover all your specific symptoms. The problem then is that it [the homeopathic product] covers a vast number of symptoms, but it may also cover [other] symptoms that [the patient] doesn't have. And so perhaps it will disrupt parts of the patient's organism which didn't need those substances, right. ... Unicist homeopathy then tries to treat the cause of the symptoms. And we [the unicist homeopaths] should ask questions of the patients ... and if it happens to be the patients' first treatment of this kind, they'll get a bit surprised, because we'll ask questions about their sleeping habits, their appetite, if they feel better near the sea or rather near the mountain ... these are some examples ... (I20: TH)

In summary, this section has focused on the internal dynamics of acupuncture and homeopathy. It has been suggested that traditional acupuncturists and traditional homeopaths, despite having shown awareness of the collective nature of their actions, disagree about how they think acupuncture and homeopathy should be practised. This shows evidence of fragmentation within CAM, which despite pursuing a collective voice, is internally differentiated. At the level of CAM practice, this could be symptomatic of a shift towards postmodernity, which, as Saks (1998:203) put it, is a condition '... based on diversity, indeterminacy, multiplicity, fragmentation and flexible specialization, in contrast to the totalizing themes of modernity'. We finally turn to and address intra-occupational divergence in terms of schools, training courses and curriculums within acupuncture and within homeopathy.

Competing Schools and Competing Curricula

Competing schools and competing curricula provide further clear evidence of internal fragmentation particularly among traditional acupuncturists. The existing conflicts

between different schools of acupuncture have resulted in heterogeneous training for traditional acupuncturists in the country and have raised the problem of quackery among CAM practitioners. One novice traditional acupuncturist denounced the anarchy within acupuncture curriculum, by stating that:

There are no rules in relation to this profession [acupuncture] and this increases the number of unqualified professionals ... I mean, if there aren't credible schools, because that's true that there aren't ... because there are acupuncturists like me with a degree in acupuncture, with clinical practice, and then there are others who have completed a three month course who practise in the same way as I practise, right. (I1: TA)

Another traditional acupuncturist leader and representative from the *Professional Association of Acupuncture and Traditional Chinese Medicine* (APAMTC), when questioned about the spread of associations of acupuncture in the country, suggested that he doubted that all acupuncturists/TCM practitioners in the country are delivering high quality care:

I: Well, to be honest perhaps there is only one [credible acupuncture's association], right.

JA: Which is yours ...

I: Of course. That's obvious. All the others they are a fake because they are representative of nothing. Because they don't represent the acupuncturists or the traditional Chinese medicine doctors. So, they are people with a very short training and so cannot be compared [to us]. That's like I said: five hundred hours cannot be compared to five thousand [hours of training]. (I6: TA)

This same respondent also disclosed that the proposal submitted by the representative of acupuncture on the CAM Committee to set the standards for this therapy in Portugal has generated a great deal of friction among other traditional acupuncturist leaders. The representative of acupuncture on the CAM Committee, José Faro, is also the president of the APAMTC. It is not surprising that the proposal for acupuncture draws on most of the APAMTC's views on the adequate standards for this therapy. The following statement from the last traditional acupuncturist leader shows how he perceived the reactions of other acupuncturists to the proposal on acupuncture submitted by the Committee to the DGS:

The problem is that the Association [the APAMTC] proposed ... to establish a set of minimum criteria to prove that those persons [the traditional acupuncturists]

were in effect acupuncturists or TCM's practitioners. They [some acupuncturists] didn't accept that. They were absolutely frightened. And then they started gossiping about the president [of APAMTC] (I6: TA)

As the last quotation shows, tensions within 'elite' groups in acupuncture have been evident. These findings are very similar to those of Gilmour et al. (2002:163) which focused on acupuncturists/traditional Chinese medicine practitioners in Ontario, Canada, where 'clearly the leaders did not have one shared concept of how a well-qualified acupuncturist or TCM practitioner should be trained'. Factions within acupuncture are well known by the CAM community in the country, as the following statement from a rank-and-file traditional acupuncturist reveals:

I cannot see [name of the traditional acupuncturist leader] doing a competency exam in the [name of the school]. I cannot see it. And it seems that he has to do it. But I really don't see [that happening]. (I3: TA)

Among homeopathic leaders, the term 'homeopeta' was used a few times to label those homeopaths with dubious homeopathic training. The word 'homeopeta' is a pun on the Portuguese words 'homeopata' (homeopath), and 'peta', a slang term for lying. As a homeopathic leader and representative of the *Portuguese Homeopathic Association* ironically stated:

JA: Are there many homeopaths in Portugal?

I: Homeopaths I [only] know a few of them. We are very few. There are *homeopetas*, then. There are a lot of *homeopetas*.

JA: Really?

I: I don't know. I think there are [lots of *homeopetas*, unqualified homeopaths]. But in relation to my association ... I talk on behalf of my association... We are very few. We are 25, 30. And they are all renowned ... we don't have any members having trouble with anyone else, with the Court, with nothing. (I12: TH, my emphasis)

In summary, it can be said that 'group cohesion' (Kelner et al., 2006) within CAM is far from being achieved in Portugal. Strategies of demarcation of acupuncturists in relation to homeopaths drew upon claims of lack of scientific evidence of homeopathy, when compared to acupuncture. The lack of consensus around the 'authentic' way of practising acupuncture and homeopathy was evident. Furthermore, the clash between schools and leaders in their claims over the right to establish criteria for the

credentialing of traditional acupuncturists and traditional homeopaths was significant. We should now turn to the discussion and will make some final considerations.

9.4. Discussion

In this chapter the following research question has been addressed: To what extent has the interplay between the medical profession and CAM practitioners in Portugal been consensual? The five previous chapters have illustrated a major conflict between CAM and the medical orthodoxy with regards to CAM's legitimacy in Portugal. This chapter, however, has suggested that the convergence of attitudes, ideas, positions, beliefs and views on CAM within the medical profession and within CAM are far from clear-cut. The analysis suggested a fragmentation in the way the medical profession and CAM practitioners positioned themselves towards CAM legitimacy, which makes the issue of the interplay between these two stakeholders in the Portuguese society more complex.

The present chapter has suggested that the medical profession has not been a 'monolithic entity' (Sharma, 2000) and has adopted different stances towards CAM. This has been evident, for instance, in the context of the relationship between the institutional elite of the PMC and the rank-and-file medical doctors. Furthermore, it seemed that the extent to which the medical doctors blamed their institutional body often depended on their commitment to CAM and on the CAM modality they practised. On the one hand, medical homeopaths often showed hostile attitudes towards the PMC as they did not agree with the Council's negative stance towards homeopathy as well as with the Council's unequivocal acceptance of a scientifically based model of healthcare. Medical acupuncturists, on the other hand, tended to express more positive attitudes towards the Council, as acupuncture is now medically legitimised and thus they no longer need to challenge the medical orthodoxy. They have joined forces with the Council, as they need to protect their newcomer medical competency in acupuncture. Finally, even those who seemed more attached to the scientifically based healthcare practice expressed a sense of dissatisfaction with the Council, which was represented as the 'elite'.

The fragmentation of the medical profession was also visible at the level of the individual practitioner. Firstly, as Hirschorn (2006) pointed out, conventional medicine is by no means a homogeneous professional body as it accommodates a plurality of

practices and knowledge forms. This means that there are medical doctors more oriented to technical, objective, scientific forms of knowledge, while there are others more familiarised with indeterminate and everyday forms of knowledge which can be easily found in CAM therapies. Hirschhorn (2006) demonstrates this plurality of knowledge forms by referring to different medical specialities and by showing how a surgeon and a medical homeopath represent the two extremes of medical knowledge. The stigmatised way the medical doctors committed to CAM therapies feel in relation to their colleagues, who see them as ‘medical heretics’ (Wolpe, 1990), ‘deviant insiders’ (Dew, 2000), ‘dissenters’ (Goldstein et al., 1987) or ‘rule breakers’, provided good evidence of internal fragmentation within the medical profession.

Internal fragmentation within CAM has been also identified in this chapter. Firstly, medical and traditional acupuncturists attempted to separate themselves from medical and traditional homeopaths on the grounds of acupuncture’s scientificity. A few acupuncturists even discredited homeopathy in the same way as orthodox medical doctors. This may be indicative of the heterogeneity that remains within the CAM field. As Broom and Tovey (2008:3-4) have noted:

... CAM is ultimately a constructed and dynamic entity that is historically and culturally variable. ... CAM does not exist *per se*. ... Rather, actors reposition themselves, they enlist other actors (and artefacts) and they shift, maintaining certain features and drawing in others.

Secondly, CAM practitioners’ views of their scope and standards of practice and their education and training were far from uniform. The debate around the ‘authentic’ way of practising acupuncture and homeopathy was evident mainly among traditional acupuncturists and traditional homeopaths. For example, while there has been a more progressive faction of traditional acupuncturists and traditional homeopaths who have been eager to be co-opted and to cease fighting with the medical profession, there has been another more traditionalist faction who has tended to be more loyal to what they perceived to be the historical roots and foundational principles of acupuncture and homeopathy. Classical acupuncturists and unicist homeopaths, for instance, tended to link ‘symptomatic’ acupuncture and ‘complex’ homeopathy to a standardisation and allopathisation process of homeopathic treatment and to the financial interests of the pharmaceutical industry.

In light of this, it can be said that camisation, or the promotion of CAM treatments and solutions to human problems, has encouraged further fragmentation within the medical profession, as the latter has broken up into diverging factions with fragmentary views on CAM and medical practice. Furthermore, camisation has led to changes in mainstream healthcare, with the emergence of multi-skilled medical doctors practising 'medical acupuncture'. Camisation has also encouraged intra-occupational fragmentation within CAM. The lack of consensus among CAM practitioners about whether they should act strategically for the sake of CAM's rapid integration in mainstream healthcare (opting for a market-oriented approach to CAM such as 'symptomatic acupuncture' or 'complexist homeopathy'), or whether they should maintain a traditional worldview in sympathy with CAM origins (opting for a 'classical' acupuncture or 'unicist' homeopathy), showed signs of fragmentation. Such fragmentation in turn can be seen as symptomatic of a postmodern condition, which delights in this plurality of discourses within healthcare.

The consequences of this fragmentation for the success of camisation and CAM legitimacy in Portugal may be considerable. As Gilmour et al. (2002:170) have pointed out, 'competition between CAM occupations can stand in the way of any group achieving the status of a profession'. At the moment in Portugal, since the approval of the Act 45/2003, little progress has been made, as CAM therapies and CAM practitioners remain unregulated by the State. The Committee charged with the regulation of CAM has itself been a major site of disagreement, not only between medical orthodoxy and CAM, but also among CAM practitioners themselves. In this sense, CAM's internal pluralism might have functioned as a 'source of structural instability' (Hafferty and Light, 1995) within CAM. Seeking statutory regulation therefore may not be enough to acquire legitimacy while structural fragmentation persists.

CAM's internal fragmentation has therefore provided resistance to the process of camisation. For instance, internal pluralism may have undermined the role of CAM practitioners as a countervailing power, as these professionals appear to behave in a non-cohesive way, not contributing to the goal of rapid recognition of CAM and CAM practitioners by mainstream healthcare and mainstream healthcare professions. This weak 'group cohesion' (Kelner et al., 2006) may increase the number of CAM practitioners who prefer to eschew the process of their own regulation for a variety of

reasons – perhaps because their views diverge from those of the Committee, or they do not agree with the proposed strategies of integration of CAM into mainstream healthcare, or they want to opt for individualised ways of professionalising. Baer (1998), for instance, has pointed out how lay homeopaths and lay acupuncturists in California have resisted professionalisation by circumventing the licensing requirements for practising heterodox practices.

It is now time to turn to the conclusions of this research, where a summary of this study and overall conclusions will be presented, alongside the contributions to sociology, limitations of the research and some recommendations for future research.

CHAPTER TEN

CONCLUSIONS

10.1. Introduction

The aim of the research reported in this study has been to analyse the current relationship between CAM, the medical profession and the State in Portugal. What has been shown so far has contributed to sociology of CAM and sociology of health professions by adding the case study of acupuncture and homeopathy in Portugal to existing research. This final chapter draws together the findings of this study. It is divided into three main sections: in the first section, the main research questions will be revisited and answered; in the second section, the main findings of the research will be discussed under specific themes; finally, suggestions for future research will be presented.

10.2. The Research Questions

This study is about CAM practitioners as a countervailing power and their relationship with the interested groups of the medical profession, the State and health corporations. It has therefore attempted to answer the following overarching research questions: Is the relationship between CAM, the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred? We should return to these overarching research questions and answer them after presenting the seven subsidiary research questions generated by the review of the literature and outlined in Chapter Two. These questions and the answers to them will now be addressed.

What main strategies have CAM practitioners used to promote alternative conceptualisations of healing within mainstream healthcare in Portugal?

Main strategies of closure have been enacted by CAM practitioners in order to achieve occupational control over a work domain in the Portuguese healthcare market: that is, to camicise healthcare. The desirable outcome of CAM practitioners' recent strategies is camisation, or the process of promoting CAM treatments and solutions to everyday human problems. Strategies of inclusion and demarcation were identified. Expressing countervailing values which have been left behind by biomedicine, professionalising by increasing 'institutional' and 'occupational' credentialism (Freidson, 1986), and

forming alliances with the medical profession have been the main strategies used by CAM practitioners to attempt to achieve inclusion within mainstream healthcare. Demarcating themselves from biomedical knowledge and from internal charlatanism were other strategies of closure which aim to camicise health and healthcare.

To what extent has the Portuguese political context sustained the success of CAM practitioners' strategies?

In 1996 a working group on CAM legislation was set up by the government and in 1999 a report was submitted to the General Directorate of Health (DGS) which sowed the seeds for CAM regulation. This created a suitable political soil to nurture CAM practitioners' strategies to camicise healthcare. Later on, the passing of the Bill 45/2003 regulated six CAM therapies and in 2004 an ad hoc Committee was set up and tasked with the elaboration of the proposals on CAM regulation. However, despite having sowed the seeds for CAM regulation, the Portuguese government has held back from legitimising CAM. CAM legislation has not yet been implemented and CAM practitioners remain marginalised by the State. In conclusion, the State has retreated from completing CAM legislation and has undermined the success of CAM practitioners' strategies. More recently, however, in January 2012, after almost one decade from having started the regulatory process of CAM, and after political pressure mainly from the Left Bloc (BE) party, the DGS presented a Bill proposal on CAM to the ad hoc Committee. This document has provoked much debate about its legal existence, with some representatives of the Committee perceiving it as a usurpation of the Committee's functions by the DGS.

To what extent have CAM practitioners and the medical profession influenced State policy in Portugal?

In the late 1990s the countervailing power of CAM practitioners was strong enough to increase governmental interest in CAM regulation. CAM practitioners persuaded the government to set up a working group on CAM and stimulated two political parties, the Left Bloc Party (BE) and the left-of-centre Socialist Party (PS), to submit CAM Bill proposals to Parliament. This countervailing power of CAM practitioners resulted in the passing of the Bill 45/2003 which regulated six CAM therapies: acupuncture, homeopathy, osteopathy, naturopathy, fitotherapy and chiropractic. This new Act was favourable to the professionalising project of CAM practitioners, as it did not restrict

CAM practice to the medical profession. However, since its passing, the Act 45/2003 has not yet been implemented. The countervailing power of the medical profession has been strong enough to influence State policy on CAM. The governmental approval of some PMC's claims such as the medical 'gaze' (Foucault, 1973) over the ad hoc Committee, the conceptual shift from 'non-conventional medicines' to 'non-conventional therapeutics' and the emphasis on evidence-based CAM, showed evidence of the medical profession's influence on State policy regarding CAM.

To what extent has CAM been incorporated into the medical establishment in Portugal?

At the moment, acupuncture is the only CAM therapy that has been incorporated into the medical establishment. In 2001, the *Portuguese Medical Society of Acupuncture* was set up and in 2002 the Portuguese Medical Council (PMC) limited 'medical acupuncture' to medical doctors. Since then, 'medical acupuncture' has been taught in Portugal to medical doctors as a medical 'technique' incorporated within their biomedical arsenal. This incorporationist scenario pertaining to acupuncture has not been observed in the institutional reaction to homeopathy. Although homeopathic practice has been present for a long time within a faction of medical doctors who have sought medical legitimacy, the PMC still prohibits and attacks it. So in the case of homeopathy, incorporation is only visible at the individual level of practice. It can thus be argued that there has been a differential incorporation of CAM into the medical establishment.

How have orthodox medical doctors responded collectively to CAM practitioners' attempts to influence healthcare provision in Portugal?

At a collective level, orthodox medical doctors not committed to CAM and thus not in direct competition with CAM practitioners, have accepted the latter as a subordinate occupational group, thus replicating in this way a traditional model within professions. They would be keener to accept CAM practitioners if the latter would restrict their practice to treating specific health conditions. Furthermore, orthodox medical doctors saw themselves as managers of health and healthcare and as gatekeepers of CAM services and delivery, i.e. of camisation.

How have medical acupuncturists and medical homeopaths responded to CAM practitioners' attempts to encroach upon healthcare provision in Portugal?

In contrast with orthodox medical doctors, medical acupuncturists and medical homeopaths have adapted to the countervailing actions of CAM practitioners and have exercised their own countervailing power by taking over acupuncture and homeopathy; they have also delegitimised the professional project of CAM practitioners by picturing it as unnecessary to mainstream healthcare; finally, they have self-improved, by reskilling themselves with old medical values that have been lost by medicine and that have been taken over by CAM practitioners.

To what extent has the interplay between the medical profession and CAM practitioners in Portugal been consensual?

The research reported here found a significant degree of fragmentation within the medical profession and within CAM. On the one hand, the medical profession has split into new professionalising factions which have sometimes differed from their elite institution, the Portuguese Medical Council, and from the collective level of orthodox medical doctors. The figures of 'medical acupuncturist' and 'medical homeopath' are good examples. On the other hand, divisions were apparent within CAM. The traditional/medical acupuncturists showed attempts to separate themselves from traditional/medical homeopaths on the basis of the lack of scientific evidence of homeopathy. Furthermore, competing definitions of 'acupuncture' and 'homeopathy' and competing schools and curricula were evident. Thus, it can be argued that the lack of consensus among CAM practitioners has undermined CAM regulation and camisation.

In conclusion, CAM's relationship with the medical profession and the State in Portugal is changing, despite the length of the process and the traditional tendency of the medical profession to resist to change and influence governmental agenda. CAM practitioners have been a source of countervailing power from the late 1990s and have been able to influence State policy and challenge the medical profession. Nonetheless, at present this changing relationship has matched medical profession's interests. Despite the progress made in CAM regulation, the medical profession has been given the conditions to maintain its sovereign position within mainstream healthcare.

The research questions presented here are important in that the answers to them start to fill the gap with regards to the sociology of CAM in Portugal, where this sociological field has yet to be consolidated. Consequently, the relationship between CAM practitioners and other stakeholders in Portuguese healthcare such as the medical profession, the State and health corporations is still an understudied topic. In a broader sense, this research has also attempted to contribute to the field of medical sociology, and to the field of sociology of professional groups in Portugal, by emphasising the role of CAM practitioners as a new professionalising group and countervailing force that has promoted the camisation of healthcare. We should now recall and summarise the key themes of this research.

10.3. Key Themes

In this research the interaction of CAM practitioners with the medical profession, the State and health corporations such as the pharmaceutical industry was a main focus of analysis. The findings presented here suggest six key sociological themes arising from this analysis: (1) CAM practitioners as a countervailing power; (2) camisation of healthcare; (3) subordination vs. differential incorporation of CAM; (4) fragmentation of the medical profession; (5) CAM's lack of cohesion; and (6) towards postmodern healthcare? We should now address each of these sub-sections in more detail.

CAM Practitioners as a Countervailing Power

As Light (2005:217) stated, the concept of countervailing power 'is not confined to buyers and sellers; it includes a handful of major political, social, and other economic groups that contend with each other for legitimacy, prestige, power, as well as for markets and money.' Furthermore, as Light (2000:204) also stated, 'the time frame for shifts in countervailing powers can be years or decades. Dominance slowly produces imbalances, excesses, and neglects that offend or threaten other countervailing powers and alienate the larger public'. In this study, CAM practitioners have been presented as an interest group who has taken collective action in order to acquire legitimacy within mainstream healthcare in Portugal. It has been suggested that CAM practitioners can be seen as a 'countervailing-power' (Light, 2010) which has promoted its own interests within the field of healthcare and has tried to impact not only competing forces such as the medical profession, but also other parties such as the State and the pharmaceutical industry. CAM practitioners have used a set of strategies to promote their own interests.

Strategies of inclusion and of demarcation were identified by the research reported here and have already been mentioned in this chapter.

There has been relatively little empirical research on CAM practitioners as an emerging countervailing power in the field of health. Kelner et al. (2004, 2006) have been one of the few who have taken up this perspective in their studies about the professionalisation of selected CAM occupational groups in Ontario, Canada. As they stated in their study on homeopathy and chiropractic, ‘the interplay between the group [CAM], the other health professions, the State, and the public, determines how far an occupation can go in the professionalising process’ (Kelner et al., 2006:2625). In a way, Kelner’s study as well as the research reported here have sought to challenge the tendency in the sociology of health professions to look at CAM through a (Freidsonian) professional-dominance lens, where CAM practitioners are often presented as dominated actors, subjugated by the power of the medical profession. Instead, they have looked at CAM practitioners as a major party which has organised against medical dominance in order to change and rearrange power relations (not only with the medical profession, but also with other key stakeholders such as the State, health corporations and the lay populace). The research reported here has sought to develop a focus on a more pluralistic perspective and to consider the countermoves of CAM practitioners and other interest groups in reshaping healthcare markets and in repositioning authority.

The concept of countervailing powers goes hand in hand with the concept of corporate powers. As Collyer (2004) has stated, CAM practitioners have gained corporate power by shifting to a mature market sector. The market sector is made up of groups of interest ‘... pursu[ing] strategies serving their own interests’ (Saks, 1995a:98). Having corporate power means having those powers necessary to successfully carry out the purposes and interests of organisations or groups. It was predicted in Chapter Six that the relationship between the Portuguese Medical Council (PMC) and homeopathy in Portugal, for example, is likely to change if homeopathy manages to increase the interest of the pharmaceutical industry. This prediction is based on the already documented enlargement of homeopathic remedies’ market (Goldstein, 2002), on the shift of CAM from a ‘cottage industry’ to a ‘big business’ (Collyer, 2004) and on the traditional power of the pharmaceutical industry to reorient not only the medical profession, but also the State’s interests, in line with industry interests (Abraham, 2009).

In summary, CAM practitioners have become active players and a countervailing power in the field of healthcare in Portugal. For this reason, CAM practitioners appear to have been a potential engine for change in (Portuguese) healthcare (Light, 2000). CAM has relied on complex organisations such as the State to carry out its main aim of camicising healthcare. The State, then, has capitalised on CAM, as the latter can offer low-cost healthcare alternatives. The State has granted corporate power to CAM, by nurturing the conditions for CAM practitioners to successfully apply their strategies and by protecting these professionals. This current ability of CAM practitioners to ally with the State, however, can be a double-edged sword. Such an alliance with the countervailing power of the government can be beneficial as it can enhance professional power of CAM practitioners; however, the strong and traditional link between the State and the medical profession in Portugal can undermine the countervailing power of CAM. The nine-year period of governmental inertia in relation to CAM regulation has brought benefits to the medical profession, for instance. The latter has been given manoeuvring space to take over CAM and therefore to extend the scope of medical practice, and consequently to reinforce the dominance of the biomedical system within mainstream Portuguese healthcare.

Camisation of Healthcare

The original concept of camisation has been introduced in a sustained way in this research. It has been defined as the process by which CAM practitioners have attempted to promote CAM solutions and treatments to human problems within Portuguese society. Camisation has been the desirable outcome of a set of multi-level strategies that have been enacted by CAM practitioners in Portuguese society. In Chapter Five, it was shown that camisation has not been fully legitimised at the institutional level of the State, as the latter is holding-up the regulation of CAM and CAM practitioners. Furthermore, camisation has been only partially legitimised by the dominant structure of the Portuguese Medical Council (PMC), which has only regulated ‘medical acupuncture’ for medical doctors and has excluded homeopathy on the basis of its ‘unproven’ results. Camisation therefore, of which intensity, degree and range could be explored through an analysis of the expansion of CAM treatments in mainstream healthcare (in principle provided by CAM practitioners), has been difficult to develop due to structural constraints.

Camisation is closely related to the key concept of ‘medicalisation’ (Conrad, 2007),

which refers to the process by which human problems are translated into medical problems. In Conrad's (2007:5) words, 'the key to medicalisation is definition. That is, a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or 'treated' with a medical intervention' (Conrad, 2007). In a similar way, the key to camisation is also a definitional one. CAM language, CAM ideology and CAM interventions and procedures are also main sources for this process. Furthermore, while medicalisation has been encouraged by a faith in science and progress and by the prestige of the medical profession (Conrad, 2007), camisation has been encouraged by opposite tendencies, i.e. a lack of faith in science and progress and the relativisation of the role of the medical doctor in society. In the same way as Conrad (2007) suggested seeing medicalisation as a form of collective action, camisation can also be seen as having a collective nature in that CAM practitioners, some of them CAM activists, have organised and exercised political pressure to propel camisation and to create a market space for it. It can be argued that camisation has a strong link with the 'medical counterculture' (Saks, 2003) from the late 1960s and the subsequent dissemination of heterodox practices which ended up forming the category of 'complementary and alternative medicine' and creating markets for camisation. Camisation, therefore, in the same way as medicalisation, might be not a static but an elastic concept, which expands or contracts through time.

Camisation has had a dual character in its relationship with medicalisation. It can weaken or reinforce the latter. On the one hand, it competes with medicalisation and creates opportunities for demedicalisation. In the research reported here, many traditional and medical acupuncturists and traditional and medical homeopaths argued that acupuncture and homeopathic treatments could be potential 'alternatives' and substitutes for biomedical treatments in, for instance, cases of chronic pain, depression, smoking, drug and alcohol addiction, persistent throat infections, migraine and insomnia, all of which are residual areas of biomedicine. These are examples of medical conditions which have been to a degree transformed into CAM conditions. It is outside the scope of this research to explore camisation, i.e. to analyse the extent to which specific human problems have undergone a camisation process. Case studies of camisation are thus much required. However, it is important to note that although camisation can be seen as a counter trend to medicalisation in that it has occurred primarily within 'residual medical areas' (Abbott, 1988), it has also acted '... to 'demedicalise' areas of life and behaviour that formerly fell well within the orbit of

medical surveillance' (Lowenberg and Davis, 1994:579). In summary, camisation can be seen as a form of, or a step toward, 'demedicalisation'.

So in the same way as medicalisation, camisation can be seen as the result of a colonisation of human conditions by CAM. Some medical conditions have been demedicalised because the 'gaze' (Foucault, 1973) has shifted from being biomedical (focused on the individual and their disease) to being focused on the individual in relation to their social context. A sort of 'CAM gaze' over human conditions has been adopted, at conceptual, interactional and institutional levels of analysis. Although Conrad (2007) addressed the position of holistic health in relation to medicalisation and pictured the former as a step towards demedicalisation, he tended to look at CAM more as a minor constraint than as a potential challenger of medicalisation. Camisation, however, can be simultaneously a challenger and an impellor of medicalisation. That is, camisation represents a reversal of the process of medicalisation, although, paradoxically, it also helps to broaden the scope of such process. For example, as a result of camisation, CAM has been taken-over by the medical profession to some extent, with an increasing number of medical doctors acquiring training in one form of CAM and broadening their field of action. Lowenberg and Davis (1994) were among the few who referred not to camisation, but to holistic health with respect to medicalisation. In an article called 'Beyond medicalisation-demedicalisation: the case of holistic health', Lowenberg and Davis (1994) acknowledged the paradox of holistic health with respect to medicalisation. According to them, holistic health has represented a shift away from medicalisation towards demedicalisation. However, at the same time it has reinforced medicalisation. As they stated, holistic health extends the pathogenic paradigm and broadens the domains of life open to intervention, and in doing so, it reinforces the medical surveillance prophecy beyond medicalisation and helps the latter to spread (Lowenberg and Davis, 1994).

As with medicalisation, camisation need not be total. It can influence to varying degrees, i.e. some human conditions have been more camicised than others, while others remain free of camisation due to previous strong, competing (biomedical) definitions. Currently in Portugal and in most Western industrialised countries, camisation has presented itself as a counterpart rather than a competitor to medicalisation. That is, biomedical definitions of human problems have generally prevailed and in many situations seem to coexist with camisation. So, camisation and

medicalisation are two processes that can mutually coexist or provide alternates to each other. This research has shown for instance the coexistence of a camisation and a medicalisation process at the level of clinical practice, with medical acupuncturists and medical homeopaths often disclosing their use of CAM alongside biomedical treatments for human problems. So, further research on the degrees of camisation might find that, in the same way as in medicalisation, there are human conditions which have been fully, partially or minimally camicised. As camisation is not a static concept, human conditions can move towards or away from total camisation.

Conrad (2007), however, suggests that in the early twenty-first century medical doctors have not necessarily been the most active promoters of medicalisation. For him, medicalisation is a process entailing the interplay of various actors. In the same vein, one can see that although CAM practitioners have been central to camisation, the medical profession has been an active collaborator in this process whilst maintaining different interests within the healthcare field. For example, by embracing CAM, medical acupuncturists and medical homeopaths have facilitated the camisation of healthcare and have, therefore, contributed to a demedicalisation of human problems. This is an important aspect, as it shows that the main gatekeepers of medicalisation have now become collaborators and gatekeepers of camisation.

For Conrad (2007), consumers can be active collaborators in the medicalisation of their problems. As with medicalisation, the current therapeutic pluralism typical of late modern societies also suggests looking at the patient as an active collaborator, and therefore driver, of camisation. Recent research has shown the existence of increasing health consumerism and therapeutic pluralism in Western developed countries, in that patients have tended to use biomedical treatments alongside CAM products and therapies (Broom and Tovey, 2008; Lopes, 2010). With regard to the Portuguese context, Lopes (2010) has shown that there has been an increase in the consumption of CAM remedies, although that consumption has not necessarily implied a rejection of biomedical treatments. So at the consumer level, camisation and medicalisation have also coexisted. Nonetheless, by having increasingly used CAM, patients have fostered CAM treatments in healthcare and have helped legitimise them.

It can be argued that the idea that the pharmaceutical industry and other health corporations such as insurance companies have been sceptical and therefore resistant to

camisation has also changed. As with medicalisation, the pharmaceutical industry has become a major player in camisation. Goldstein (2002) has pointed out that, at the level of the health corporations, the American market for CAM has enlarged, many CAM medications have been advertised by pharmaceutical companies through media campaigns directly to patients instead to their medical doctors, and many CAM products are available over the counter or in large chain stores. CAM is no longer a 'cottage industry' but a mature business (Collyer, 2004). The pharmaceutical industry has thus become a major player in camisation and a potential collaborator in the emergence of CAM markets, as these can increase its profits. As Goldstein (2002:52) has put it, 'firms such as Warner-Lambert, American Home Products, Bayer, and SmithKline Beecham [now GlaxoSmithKline] have each begun to offer their own brands of herbs'. Furthermore, the fact that insurance companies have started paying for CAM treatments for certain conditions (Frank and Stollberg, 2004), has propelled camisation. It can be argued thus that, in the same way as with medicalisation, this process can be conceptualised as the business of camisation.

Camisation is a meta-concept in that it helps to have a conceptual overview of the recent collective action of the disparate field of CAM to influence Portuguese mainstream healthcare. The concept has the potential to be an umbrella term for all those notions underpinning CAM therapies' epistemology: holistic health, well-being, and natural, less invasive and 'gentle' solutions to human problems. To summarise, as Broom and Tovey (2008:4) stated, 'what largely characterises CAM [therapies] is ... their tendency to espouse models of care that incorporate physical and metaphysical elements in treatment processes'. Camisation, in a more general sense, is thus the process by which these models of care have been promoted within mainstream healthcare in Portugal. In this sense, camisation is also a process that derives from a postmodern view of health, which emphasises the existence of a multiplicity of health ideologies.

Camisation demands closer scrutiny in order to highlight its value as a sociological concept. We have discussed so far the ways in which this concept differs from and is related to medicalisation and demedicalisation. However, its relationship with other key concepts such as 'healthicisation' (Conrad, 1992), 'deprofessionalisation' (Haug, 1976; 1988) and 'de-pharmaceuticalisation' (Williams et al, 2011) requires closer examination. Firstly, camisation appears to incorporate the concept of healthicisation, where '... behavioural and social definitions are advanced for previously biomedically

defined events' such as heart disease (Conrad, 1992:223). Thus, healthicisation involves health promotion, which is a main tenet of CAM ideology. It can thus be argued that healthicisation is a sub process of camisation, although it can also exist as a process by itself and can therefore be detached from camisation on many occasions. Secondly, to what extent is camisation conflated with the deprofessionalisation of medicine? That is, to what extent has camisation challenged professional dominance and '... led to a decline in the cultural authority of medicine and in the extent of its monopoly over health-related knowledge' (Elston, 1991:64)? This is a question which needs further study. However, one could argue that, although camisation is the result of collective action in which CAM practitioners have been the main actors, medical doctors have also been important collaborators in this process. In this sense, camisation does not seem to have produced a decline in medical action, as medical doctors have been able to adapt and have taken over the camisation of healthcare. Lastly, the relationship between camisation and de-pharmaceuticalisation is also of interest. For example, to what extent has camisation contributed to a de-pharmaceuticalisation, i.e. to a decline in the usage of synthetic chemical medications? In other words, to what extent has camisation been associated with anti-pharmaceutical sentiments? These issues need to be further investigated.

In summary, as mentioned earlier, the process of camisation has expanded in Portugal since the late 1990s, and more generally since the 1960s in Western societies. Furthermore, the complex relationship between CAM, the medical profession, the State and health corporations, as previously noted, has placed structural limitations on the extent to which healthcare has been camicised. Thus, the importance of camisation for our society and for healthcare, its characteristics, its different degrees and levels, its constraints, its effects and implications and its main collaborators need further investigation. Furthermore, the interaction of camisation with medicalisation as well as healthicisation, professionalisation and pharmaceuticalisation over time needs stronger empirical data to reinforce the arguments exposed in this research. Finally, the extent to which the camisation process described throughout this research is context and time specific (i.e. only manifested within Portuguese society at the dawn of the 21st century), and is applicable to CAM therapies other than acupuncture and homeopathy, needs further sociological research.

Subordination vs. Differential Incorporation of CAM

At the collective level of the medical profession, it seems that in Portugal the prospect of including CAM in mainstream healthcare can take the form of subordination. As noted in Chapter Seven, four main conditions had to occur for CAM to achieve legitimacy, according to orthodox medical doctors: limiting CAM jurisdiction, achieving scientific efficacy, using CAM as a residual choice and a last resort treatment, and attaining regulation and professionalism. Orthodox medical doctors who are not committed to CAM and thus not in direct competition with traditional CAM practitioners, would open the door to CAM and CAM practitioners at the expense of restricting CAM jurisdiction and accepting CAM practitioners as having a similar status to other subordinated professionals within Portuguese healthcare. These findings are in line with previous research on CAM worldwide. For instance, Kelner et al. (2004) have shown how the leaders of established health professions in Ontario, Canada, rather than ignoring the professionalisation project of CAM practitioners, spelled out a set of requirements in order for this project to be completed. As Kelner et al. (2004:925) stated, these leaders' responses implied that '... newcomers [CAM practitioners] would now have to 'jump through the same hoops [as the medical doctors]'

One of the main effects of camisation in Portuguese healthcare, however, has been the differential incorporation rather than subordination of CAM into the medical profession. As we have seen, the medical profession has, at different levels, increasingly embraced specific CAM therapies. A main way of taking over CAM by the medical profession has been incorporating CAM into the biomedical model. For example, at the moment, acupuncture is the only CAM therapy which has achieved an enhanced status within the Portuguese Medical Council (PMC). Orthodox medical doctors can acquire competency in 'medical acupuncture' and are the only credentialed professionals practising this therapy within the Portuguese health system. Acupuncture has therefore been incorporated at the institutional and also individual practice levels. Homeopathy, however, remains marginalised by the Council which does not allow the practice of this therapy by its members (orthodox medical doctors). Nevertheless, at the level of day-to-day practice, homeopathy has been a long-standing practice among medical doctors from the 19th century until this day. Homeopathy, therefore, has only been incorporated at the level of the individual practice. So this incorporation has been differential in that it has varied according to the type of therapy being considered. This means that CAM is a multifaceted and a differentiated field of practices which can exist by itself and

involve different relationships with the medical profession. Therefore, research has to be cautious in generalising results to all CAM therapies. Although the majority of CAM therapies still share the status of ‘non-essential’ or ‘unproven’ therapies when compared to biomedicine (Broom and Tovey, 2008), CAM is a dynamic field which has changed and been redefined over time. Future analysis of CAM’s relationship with the medical profession should therefore pay attention to this internal fragmentation and should adopt a case-by-case basis.

Both the subordination or the differential incorporation approach to CAM, however, have the same aims: taking control over camisation of mainstream healthcare and promoting medical doctors as ‘gatekeepers’ of CAM by determining which human conditions would benefit from CAM treatments. They are approaches that tend to reflect a modernist view of healthcare as they emphasise the professional privilege of medical doctors and the hierarchal division between CAM and orthodox medicine. Yet the coexistence of these two approaches towards CAM shows evidence of postmodern overtones by suggesting that the medical profession has become increasingly fragmented.

Fragmentation of the Medical Profession

A main effect of camisation in Portuguese society has been the fragmentation of the medical profession. In Chapter Nine, an analysis of the intra-occupational fragmentation within the medical profession was provided which suggested there is a conflict between the elite and the rank-and-file levels of the medical profession. It was also shown how the medical acupuncturists and the medical homeopaths, i.e. orthodox medical doctors who became involved in CAM, defined themselves as ‘rule breakers’ in relation to their colleagues, the medical doctors. This is in line with Dew’s (2000) concept of ‘deviant insiders’, Wolpe’s (1990) concept of ‘medical heretics’, or Goldstein et al’s (1987) concept of medical ‘dissenters’, i.e. medical doctors who committed the ‘error’ of taking up heterodox practices.

It was also shown that medical acupuncturists, because they have seen acupuncture legitimised by the PMC, tended to draw upon the Council’s views, to help protect their new competency in ‘medical acupuncture’. The ‘medical homeopaths’, however, reported a significant degree of conflict with the Council, as the latter has not recognised homeopathy and can prosecute those medical doctors who subscribed to

homeopathy. Furthermore, the research reported here acknowledged a number of medical acupuncturists and/or homeopaths with considerable levels of detachment from the public-health system and of commitment to private healthcare. So the revival of CAM in health has led to a more fragmented medical profession and thus to a broadening of professional rhetoric among different groups and sub-groups of the medical profession.

Earlier research has shown that the fragmentation of the medical profession that is happening in many Western countries at the expense of camisation is an important symptom of a shift towards a postmodern healthcare. At the knowledge level, for instance, the existence of fragmentation supports Hirschhorn's (2006) recent claims of looking at knowledge as having different forms which can be situated in a continuum rather than in a polarised form. Hirschhorn's claims are of a postmodern nature because they go against modern societies' idea of knowledge as unidirectional and science-oriented. That is to say, the modernist view that more science means more progress which means better knowledge. At the socio-historical level, the existence of fragmentation also supports Frohock's (2002:214) claim that 'the distinctions between alternative and conventional medicine are variables of time, place, and the attitudes of healthcare practitioners'.

CAM's Lack of Cohesion

The lack of cohesion of CAM, whether at an institutional level or at the level of the individual practice, appears to have been a major problem for CAM regulation in Portugal. Issues related to CAM credentialism-making have ended in clashes between institutions and leaders, mainly in the case of acupuncture. This is in line with previous studies (Welsh et al., 2004; Gilmour et al., 2002) which pointed to the lack of internal unity among CAM therapies. With regard to CAM practitioners, not only did the findings from this research report an attempt by acupuncturists (either medical or traditional) to demarcate themselves from homeopaths (either medical or traditional) on the grounds of the unscientific status of the latter, they also suggested a degree of conflict among acupuncturists and among homeopaths about the 'legitimate' ways of practising acupuncture and homeopathy. For example, 'symptomatic' acupuncture and 'symptomatic homeopathy' were contrasted to the classical views of these therapies, and within homeopathy, debates around the 'unicist' and the 'complexist' approaches to human problems were evident. In the same vein, other studies (e.g. Gilmour, 2002) had

already emphasised that CAM practitioners are divided into competing factions, with divergent ideas about how CAM treatments should be administered and who should provide them.

In summary, although CAM practitioners can be seen as a countervailing power or an organised group with its own interests in achieving legitimacy within mainstream healthcare market, it still lacks internal cohesion, which can threaten the efficacy of its actions. In the case of Portugal, although CAM practitioners represented a strong source of countervailing power in the late 1990s by being able to attract the interest of the State, the period since the passing of the Act 45/2003 has been characterised by a significant lack of unity of CAM professionals which has not helped the latter to achieve a better position in Portuguese mainstream healthcare.

Towards a Postmodern Healthcare?

The findings presented here suggested a changing relationship between CAM, the medical profession and the State in Portugal in recent times. This can be seen as an attempt by the medical profession and the State to align with CAM and its countervailing power to integrate mainstream healthcare. On the one hand, the Portuguese State has changed its attitude towards CAM and has undergone a process of attributing legal legitimacy to specific CAM therapies. Yet the State has held-up CAM regulation in the country and CAM therapies and CAM practitioners remain marginalised in Portuguese society. On the other hand, the findings have clearly shown that the medical profession has changed its position towards some CAM but not towards CAM practitioners. Moreover, the dominant structural position of and the strong corporate power attributed to the medical profession in Portugal appear to have been strong enough to counteract CAM practitioners' attempt to camicise mainstream healthcare. Medical doctors have taken over some CAM therapies and have positioned themselves in the front line of CAM's service delivery.

The task of evaluating whether Portuguese healthcare is in a transitional stage towards a more postmodern form is a difficult one. While it is impossible to deny that changes are occurring within Portuguese healthcare, there have been contradictory signs and multiple developments, some moving towards, others moving away from, a postmodern disposition towards healthcare. In a changing environment, while a faction of medical doctors has been able to adapt to maintain its position within healthcare, there have been

pockets of resistance, mainly radiating from the institutional level of the medical establishment. That is to say, while at the level of the individual medical practice postmodernity has expanded, with some medical doctors increasingly providing CAM treatments alongside biomedical treatments and thus promoting 'integrative medicine' in their daily medical work, at the level of the State or of the medical establishment the modern condition of healthcare with its authoritative biomedical model and hierarchal medical knowledge still persists. The Portuguese State, despite its initial attempts to promote plurality within healthcare, has held back from completing such a task. The incorporation of 'medical acupuncture' within the medical curriculum, despite showing postmodern overtones, attempts to accommodate the heterodox into the orthodox and in that sense contributes to reinforcing the dominance of orthodox medicine. Furthermore, as Saks points out, although CAM practitioners have presented themselves as a countervailing force which has counteracted mainstream healthcare ideology with holistic claims, some CAM therapies themselves have moved away from these claims, '... as is highlighted by the mechanistic practice of some osteopaths and chiropractors in their narrow focus on the treatment of back complaints' (1998:209-210).

To conclude, in the same way as Saks (1998:211) pointed out in relation to the British society in the late 1990s, it can also be argued that at the dawn of 21st century Portuguese society there is yet to be a postmodern profusion of heterogeneity (within health professions and mainstream healthcare), as the medical profession has maintained professional dominance and authority through incorporation and subordination of CAM. Bauman's (2000) idea of a shift from a solid to a liquid modernity, however, has been little evident within the healthcare field in Portugal, where a resistance to fluidity and to adapting to changes occurring in the social and political context and at the level of the medical practice has generally persisted. We now turn in the next section to address the main contributions of this study to sociology, taking into consideration both the methodological and the theoretical levels.

10.4. Suggestions for Future Research

Field research, mainly conducted through interviews with respondents, as French (1993:120) suggests, '... open up interesting lines of enquiry far removed from those on my carefully planned interview schedule'. These new lines of enquiry refined my sociological understanding of what further work on CAM is needed. In this section, some suggestions for future research will be presented, by combining two main fields:

the sociology of CAM and the sociology of professions. Two types of suggestions will be highlighted: (1) future sociological research on CAM within a Portuguese context and in a comparative context; (2) future sociological research on CAM worldwide, taking into account alternative methodological approaches.

Despite the recent increase of medical and governmental interest in CAM in the country, there is still a gap in the sociology of CAM (not to mention the sociology of health professions) in Portugal. From a quantitative standpoint, there is little information available about the demand for and supply of CAM providers, services and products both in private and public healthcare in the country. From a qualitative point of view, research on the relationship between CAM, well-established professional groups such as the medical profession, and other subordinate health professions such as nursing or physiotherapy, is also scarce in Portugal. As Carapinheiro and Rodrigues (1998) have stated, there is a lack of research on the professionalisation process of many occupations and on the closure strategies adopted by many occupations within the Portuguese context.

At the level of health professions, an interesting case study would be to analyse the relationship between homeopathy and another professional group, the pharmacists. Given the traditional dominant power of pharmacists (Araújo, 2005) in Portuguese healthcare, their relationship with not only the traditional, but also medical homeopaths and their homeopathic use of natural and chemical substances, appear to be interesting to analyse. Furthermore, although this research concentrates on two specific CAM therapies, acupuncture and homeopathy, further research on the remaining four would-be professions (Abbott, 1988) (osteopathy, chiropractic, phytotherapy and naturopathy) needs to be developed. For example, from the point of view of the sociology of professions, an interesting study would be to analyse the relationship between osteopaths, chiropractors, physiotherapists and medical doctors, in particular orthopaedists and psychiatrists⁴⁷, in the Portuguese context. This would give a valuable comparative study of inter and intra-professional competition within the field of health professions. Since all these professionals must dispute similar jurisdictional areas related to the manipulation of the osteomuscular structure of the body, it would be of interest to understand their field of countervailing powers.

⁴⁷ Medical doctors specialised in physical medicine and rehabilitation in Portugal.

Comparative research on CAM which demonstrates how Portugal varies from countries such as the UK, would also contribute to put Portugal in a comparative perspective. For example, it will be of interest to analyse the extent to which health and healthcare have been camicised in these two countries. Further research should have a two-fold purpose: first, the analysis of the ongoing process of promoting CAM solutions and treatments to health problems in these two countries; second, the analysis of the attempts or counter-actions of CAM practitioners to be integrated into mainstream healthcare in these same countries.

The rationale for a comparison between Portugal and the UK would be three-fold: first, both countries have universal healthcare systems; second, both countries have had significant CAM activism which has created the conditions for CAM practitioners to influence mainstream healthcare and health-policy; third, differences in the attitude of the medical profession towards CAM in Portugal and the UK seem to have cross cut differences in the acceptance of CAM therapies and CAM practitioners in these countries. A good illustration of this last aspect would be homeopathy. While the Portuguese medical establishment seems to be conservative and therefore resistant to this therapy, the British medical profession seems to have aligned, although in different ways, with the countervailing power of homeopaths. Homeopathy is a therapy with a long tradition and high status within the British medical circle but seen as fake and still banned by the Portuguese Medical Council. In sum, by capitalising on similarities and differences between Portugal and the UK with respect to CAM status, the researcher will be in a better position to expand her understanding of the process of camisation of health and healthcare and to isolate the key factors responsible for differences in status of CAM across these two countries.

It is also vital to generate data on the changing relationship between CAM, the medical profession and the State worldwide by using methodological approaches such as focus groups, observations (of consultations for example) or, as Saks (2004) suggested, biographic narrative methods. For instance, using biographic narrative methods would have the advantage of situating the relationship between CAM and the medical profession historically, i.e. a relationship which is always mutating in unique historical and social conditions. Using biographic narrative methods for instance to analyse 'the detached' medical doctors and their personal and professional experiences with CAM over time would be of value for the sociology of CAM and of professions. As Goldstein

(1987) stated a while ago, it appears that there is a strong link between personal experiences with CAM and professional attitudes towards CAM. Furthermore, this would help shed some light on the analysis of the current fragmentation of the medical profession with the emergence of new professionalising factions which incorporate heterodox practices.

Furthermore, the expansion of CAM in Western countries has recently generated models of collaboration, rather than subordination or incorporation of CAM. Research on 'integrative' clinics or places inside healthcare settings where CAM practitioners have worked in collaboration (in theory) with medical doctors or other allied health professionals in the Portuguese context would be of value.

Analysing the relationship between CAM, the State, the medical profession, and other players such as the lay populace, the pharmaceutical industry and health insurance companies as new sources of countervailing power and drivers of camisation would be also sociologically valuable. Much of the sociological research on CAM conducted up until now has not tended to assume the plurality of countervailing forces in shaping healthcare but instead has concentrated on a two-sided relationship between CAM practitioners and the medical profession lying predominantly within a neo-Weberian closure approach. The research reported here, for example, suggested that greater attention should be paid to the role of the lay populace in legitimising CAM practitioners and in boosting camisation. At the moment in Portugal, the process of camisation seems to be under patients' patronage. Furthermore, part of the strategies of closure used by CAM practitioners in the study reported here were patient-centred. Thus, an analysis of the lay populace as a countervailing force in relation to biomedical dominance and as a patron of 'nonphysician providers' of CAM (Hartley, 2002) within mainstream healthcare is necessary.

The relationship between CAM practitioners and the State has clearly become stronger in the last ten years. However, research on the relationship between CAM and third party players such as the pharmaceutical industry or healthcare insurance companies is still underdeveloped worldwide, and when they are analysed, they are not often central to the analysis. This study gave limited consideration to the role of the pharmaceutical industry and failed to present strong and clear empirical evidence of the actions of this countervailing actor in relation to CAM and the subsequent implications of these

actions for other players in the field such as the State and the medical profession. Also, the recent move of healthcare insurance companies to include CAM therapies in their insurance schemes (Frank and Stollberg, 2004) in different Western countries including Portugal (with the case of Multicare and their 2011 health plan on 'Integrative Medicine' being a good example⁴⁸) has been too important to be ignored. So, there is the need for further research in this area. New actors in the field of healthcare can represent potential sources of countervailing power to traditional dominant actors such as the medical profession or the State and can contribute (or not) towards the development of camisation within healthcare.

The research reported here adds to the existing body of knowledge in sociology of CAM and health professions by using a countervailing power theory to analyse CAM's relationship with key players in healthcare. Furthermore, this research adds to Saks's concept of incorporation by showing CAM's differential incorporation at the institutional level. By identifying increasing fragmentation within the medical profession and CAM, the research reported here suggests that opting for a qualitative approach to the medical profession and CAM as two whole cohesive bodies may thus be an inadequate methodology; intra-professional fragmentation should be taken into account when studying the relationship between professionalised and professionalising groups such as the medical profession and CAM; recalling Freidson (1970a:186), this will help us understand the difference between what a professional group wants its members to be, as opposed to what they actually are. Finally, this research contributes with an original concept, 'camisation', of which potential theoretical benefits for an analysis of health and healthcare deserves further investigation.

⁴⁸ <http://www.portaldeseguros.net/seguero-saude/plano-medicinas-integradas.html> (accessed on the 8th June 2012)

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Appendix 1 – Information sheet



THE CURRENT RELATIONSHIP BETWEEN COMPLEMENTARY AND ALTERNATIVE MEDICINE, THE MEDICAL PROFESSION AND THE STATE IN PORTUGAL

Research Information Sheet (English Version)

Who is the researcher?

This research is being undertaken by Joana Almeida, a PhD student at the Department of Health and Social Care, Royal Holloway, University of London, Egham, United Kingdom. The research is funded by the Portuguese Foundation for Science and Technology.

How and where can she be contacted?

If you have any queries, please contact Joana Almeida on (00351)-966176368 (Portuguese mobile phone), (00351)-214672767 (Portuguese landline) or (0044)-(0)7923834485 (UK mobile phone) or by email on J.R.S.Almeida@rhul.ac.uk or joanalmeida@net.sapo.pt.

What is the research study about?

The purpose of this research is to learn more about the contemporary relationship between complementary and alternative medicine (CAM), the medical profession and the state in Portugal. I am interested in getting your opinions about topics such as the expansion and popularity of alternative medicines worldwide and in Portugal in particular; the current regulation of six CAM therapies by the Portuguese government; the integration of CAM in the Portuguese healthcare system; the effectiveness and use of CAM; and your definitions of orthodox and unorthodox medical practices.

What will I have to do and how long will it take?

You will be invited to speak with the researcher, who will ask you to comment on some aspects of the trends mentioned above, as well as to answer some specific questions about your professional practice and experience. The interview itself is expected to take between 60 and 90 minutes of your time. It will be open-ended and the questions themselves are quite broad. Also during the interview you will find me writing some notes down. I am just making sure that I do not forget to ask you about all aspects of the topic.

What will happen to the information collected?

All the information you will give during the interview will only be used for research purposes. The data collected will be analysed for the researcher's dissertation and will also provide the basis for conference papers and articles in professional journals.

What degrees and kinds of confidentiality and anonymity will be required for this research?

All the information you give during the interview will be treated in confidence by the researcher and her supervisor and kept securely. Anything you say will be reported anonymously in my dissertation and subsequent publications.

Thank you for reading this form and for taking the time to speak with me.



A ACTUAL RELAÇÃO PROFISSIONAL ENTRE AS TERAPÊUTICAS NÃO CONVENCIONAIS, A PROFISSÃO MÉDICA E O ESTADO EM PORTUGAL

Folha Informativa (Portuguese Version)

Quem é a investigadora?

O presente estudo está a ser realizado por Joana Almeida, estudante de doutoramento no *Department of Health and Social Care, Royal Holloway, University of London*, Egham, Surrey, Reino Unido, e com o apoio financeiro da Fundação para a Ciência e a Tecnologia (FCT).

Como contactar a investigadora?

Poderá contactar a investigadora preferencialmente por email: j.r.s.almeida@rhul.ac.uk ou joanalmeida@net.sapo.pt, ou por telefone – (00351)-966176368 (telemóvel português) ou (0044)-(0)7923834485 (telemóvel inglês).

Em que consiste o presente estudo?

O objectivo do presente estudo é contribuir para o conhecimento sobre a actual relação profissional entre as terapêuticas não convencionais (TNCs), a profissão médica e o Estado em Portugal. A investigadora está interessada em conhecer as suas opiniões e pontos de vista acerca de vários tópicos, tais como: a expansão e popularidade das TNCs no mundo ocidental e na sociedade portuguesa em particular; o processo de regulamentação de seis TNCs em curso na sociedade portuguesa; a integração destas TNCs no sistema de saúde e bem-estar português; a eficiência e uso destas terapêuticas; as suas definições de práticas médicas ortodoxas e não ortodoxas, de médico e de terapeuta não convencional.

O que irá ser pedido e quanto tempo irá tomar?

Írá ser convidado a falar com a investigadora, que lhe pedirá para comentar certos aspectos já atrás mencionados, assim como para responder a algumas questões sobre a sua prática e experiência profissional. A entrevista em si demorará cerca de 60 minutos. A maioria das questões é de carácter aberto e geral. Ao longo da entrevista poderá ver-me a ler e a tomar pequenas notas, apenas no sentido de não me esquecer de abordar todos os aspectos relacionados com o estudo.

O que vai acontecer à informação recolhida?

Toda a informação obtida através da entrevista irá ser gravada com o seu consentimento e utilizada unicamente para fins do presente estudo. Os dados recolhidos irão ser analisados e utilizados na dissertação de doutoramento, bem como em comunicações em conferências ou em artigos de revistas profissionais nacionais ou internacionais.

Qual o grau de confidencialidade e anonimato requerido para esta investigação?

Toda a informação obtida através da entrevista irá ser tratada de forma confidencial pela investigadora e pelo seu orientador. Os dados recolhidos irão ser seguramente utilizados de forma anónima ao longo da minha dissertação e em posteriores publicações.

Muito obrigada por ler esta informação e por demonstrar interesse e disponibilidade em participar neste estudo.

Appendix 2 – Interview Consent Form



THE CURRENT RELATIONSHIP BETWEEN CAM, THE MEDICAL PROFESSION AND THE STATE IN PORTUGAL

Interview Consent Form (English Version)

Name of respondent _____

This consent form outlines your rights as a participant in the study of the relationship between CAM, the medical profession and the State in Portugal conducted by Joana Almeida from the Department of Health and Social Care, Royal Holloway, University of London, UK.

1. I agree to be interviewed for the purposes of the research specified above.	[]
2. The purpose and nature of the interview has been explained to me, and I have read the information sheet provided by the research student.	[]
3. I agree that the interview will be taped.	[]
4. Any questions that I have asked about the purpose and nature of the interview have been answered to my satisfaction.	[]
5. I have been informed that my participation in this research is voluntary and that I am free to refuse to take part. I may refuse answer any questions and may stop taking part in the study at any time.	[]
6. I have been assured that my identity and that of my practice will remain completely anonymous.	[]
Name of respondent _____	
Signature of respondent _____	
Date _____	
7. I have explained the study and the implications of being interviewed to the interviewee and I believe that the consent is informed and that (s)he understands the implications of participation.	[]
Name of interviewer _____	
Signature of interviewer _____	
Date _____	



**A RELAÇÃO PROFISSIONAL ENTRE AS TERAPÊUTICAS NÃO
CONVENCIONAIS, A PROFISSÃO MÉDICA E O ESTADO E EM PORTUGAL**

***Declaração de Consentimento para entrevista
(Portuguese Version)***

Nome do/a entrevistado/a _____

A presente declaração sublinha os seus direitos enquanto participante no estudo sobre a actual relação profissional entre as terapêuticas não convencionais, a profissão médica e O Estado em Portugal realizado pela estudante de doutoramento Joana Almeida no Department of Health and Social Care, Royal Holloway, University of London, UK.

1. Consinto ser entrevistado/a no âmbito do estudo especificado acima.	[]
2. O propósito e a natureza da entrevista foram-me explicados e li a folha informativa que me foi entregue pela investigadora.	[]
3. Consinto que a entrevista seja gravada (gravação áudio).	[]
4. Todas as questões que coloquei sobre o propósito e a natureza da entrevista foram satisfatoriamente respondidas.	[]
5. Fui satisfatoriamente informado/a sobre a participação voluntária neste estudo, bem como sobre a liberdade em desistir a qualquer momento da entrevista. Poderei recusar responder a certas questões e abandonar a entrevista a qualquer momento.	[]
6. Foi-me assegurado que a minha identificação pessoal nesta investigação permanecerá completamente anónima.	[]
Nome do/a entrevistado/a _____	
Assinatura do/a entrevistado/a _____	
Data _____	
7. Considero ter fornecido a informação necessária sobre o meu estudo, bem como ter dado a conhecer ao/à entrevistado/a as implicações em participar nele. Acredito que a presente declaração de consentimento para realizar a entrevista é informada e que o/a participante compreendeu as implicações em participar.	[]
Nome da entrevistadora _____	
Assinatura da entrevistadora _____	
Data _____	

ROYAL HOLLOWAY, UNIVERSITY OF LONDON
DEPARTMENTAL ETHICAL APPROVAL FORM

**Appendix 3 –
Departmental
Ethical
Approval**

For staff and student dissertations and research projects involving data collection from research participants (observations, interviews, questionnaires, group discussions, recordings, videos etc.).

This form should be discussed and completed jointly by both student and supervisor (and in the case of staff, with their immediate line manager) with each keeping a signed copy of the form.

If the proposed work involves human participants, and is judged by the supervisor/line manager potentially to give rise to ethical problems, ethical approval must be sought in advance. The supervisor will recommend whether the completed/signed form and any supporting material should be considered only by the Department's internal ethical approval procedures or be referred to the College Ethics Committee.

To be completed by the applicant

(delete as appropriate)

- | | |
|--|--------|
| 1. Will the study be <i>covert</i> in any way? | YES/NO |
| 2. Will resulting data be used for purposes outside this study? | YES/NO |
| 3. Are you working with a vulnerable population? | YES/NO |
| 4. Is it possible that your study will cause distress or harm to participants? | YES/NO |

If the answer to any of the above questions is 'YES' please supply relevant supporting materials and explanations.

The working title of my dissertation/project is:

MEDICAL PROFESSION AND NON-CONVENTIONAL
THERAPEUTICS IN PORTUGAL: CONVERGENCE OR DIVERGENCE?

I am fully aware that the research carried out for my ~~undergraduate/masters~~/doctoral dissertation/study *(delete as appropriate)* requires that I take due care of ethical issues. I will ensure that consent is obtained from all participants which, saving exceptional cases will be in writing. For students - these issues have been discussed with my supervisor. For staff - these issues have been discussed with my line manager

Staff/Student Name (print below):

Signature:

Date:

RAQUEL SANTOS DE ALMEIDA

Raquel Almeida

26/02/2008

To be completed by the supervisor (students) or line manager (staff)

Issues of ethics, copyright and data protection have been considered where necessary as indicated in the attached material and appropriate measures have been recommended. All necessary materials have been seen and the Ethics Committee's *Notes for Guidance* have been consulted.

Please tick one box only:

- | | |
|--|--------|
| 1. No referral necessary | [] |
| 2. Form to be referred to department ethical approval procedures | [] |
| 3. An application must be made to the College Ethics Committee | [] |

(For 2. and 3. please append supporting documents as required eg. research project proposal, questionnaires, consent forms.)

Line Manager/Supervisor Name (print below):

Signature:

Date:

Janette Cole

J. P. Cole

26/2/08

Appendix 4 – List of organisations/associations from which individual members were approached

Abel Salazar Biomedical Science Institute (Instituto de Ciências Biomédicas Abel Salazar, Universidade do Porto – ICBAS/UP), which offers postgraduate courses in ‘medical acupuncture’ to orthodox medical doctors

Advanced Studies in Naturology (Estudos Avançados de Naturologia – EAN)

Consultative Technical Committee on CAM (Comissão Técnica Consultiva das Terapêuticas não Convencionais – CTCTNC)

Hippocrates Institute for Education and Science (Instituto Hipócrates de Ensino e Ciência – IHEC), a Department of CAM from Lusófona University, one of the largest private universities in Lisbon, which offers training in specific CAM therapies

Homeopathic Society of Portugal (Sociedade Homeopática de Portugal – SHP), whose members are generally medical doctors and allied healthcare professionals

International Association of Traditional Medicine and Healthy Activities (Associação Internacional de Medicinas Tradicionais e Atividades Saudáveis – SALVA)

Lisbon Undergraduate School of Technology and Arts (Escola Superior de Tecnologias e Artes de Lisboa – ESTAL)

National Council of Naturologists and Specialists of Non-Conventional Therapeutics (Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas não Convencionais – CNNET), whose members are generally non-medically qualified CAM practitioners

National Federation of Natural Alternative Medicine’s Associations (Federação Nacional de Associações de Medicinas Alternativas Naturais - FENAMAN)

Portuguese Association of Homeopathy (Associação Portuguesa de Homeopatia – APH), whose members are generally ‘traditional homeopaths’

Portuguese Medical Society of Acupuncture (Sociedade Portuguesa Médica de Acupuntura – S.P.M.A.), whose members are medical doctors

Portuguese Society of Homeopathy (Sociedade Portuguesa de Homeopatia – SPH), whose members are generally medical doctors, allied healthcare professionals and might have other members without previous biomedical background

Professional Association of Acupuncture and Traditional Chinese Medicine (Associação Profissional de Acupuntura e Medicina Tradicional Chinesa - APAMTC)

Appendix 5 – Interview topic guides



CAM's CHANGING RELATIONSHIP WITH THE STATE AND THE MEDICAL PROFESSION IN PORTUGAL

CAM Practitioners' Interview Topic Guide (Traditional Acupuncturists and Traditional Homeopaths) (English Version)

1. Approaching the topic

- Awareness of the increasing use of CAM therapies, worldwide and in Portugal in particular;

2. CAM professionalisation and regulation

- CAM practitioners' views on the attempts of CAM therapies to become professions (i.e. with autonomy, formal qualifications, professional bodies or associations, codes of ethics, demarcation from the amateurs, etc.);
- CAM practitioners' views on the importance of CAM therapies as professions;
- CAM practitioners' views on the ability of CAM therapies to become professions;
- CAM practitioners' views on the current relationship between the State and CAM;
- CAM practitioners' views on the statutory regulation of six specific CAM therapies in Portugal;
- CAM practitioners' views on the impact of CAM regulation on the medical profession and medical practice, and on CAM as a whole occupational group;

3. Strategies to gain status/power within mainstream healthcare

- CAM practitioners' definitions of orthodox and unorthodox medical practice;
- CAM practitioners' views on the role of CAM therapies as complementary and/or alternative practices;
- CAM practitioners' perceptions about being a physician and a CAM practitioner;
- CAM practitioners' views on the use and efficacy of CAM;
- CAM practitioners' views on their relationship with orthodox medical doctors;

4. CAM challenges to the medical profession

- CAM practitioners' views on the less satisfactory aspects of mainstream healthcare;
- CAM practitioners' views on the role of CAM to improve health and the healthcare services;
- CAM practitioners' views on the future status of CAM within mainstream healthcare;

- The extent to which CAM practitioners believe that CAM has challenged medical practice;

5. Intra-occupational relationships

- CAM practitioners' perceptions about CAM as a professional group with collective identity;
- CAM practitioners' perceptions about the position of CAM as a cohesive group towards the regulation and professionalisation of CAM;
- CAM practitioners' perceptions about the relationship between the different CAM therapies;

6. Reasons for choosing a CAM modality

- Reasons why traditional homeopaths/traditional acupuncturists chose to specialise on this professional area;

Biographical data

Date

Sex

Age

CAM therapy

Years of CAM practice

A RELAÇÃO PROFISSIONAL ENTRE A PROFISSÃO MÉDICA E AS TERAPÊUTICAS NÃO CONVENCIONAIS EM PORTUGAL

Guião de Entrevista – Profissionais das TNCs (Acupunctores e Homeopatas Tradicionais) (Portuguese Version)

1. Abordagem do tópico

- Percepções acerca das actuais dinâmicas das TNCs no mundo e na sociedade portuguesa em particular;

2. Profissionalização e regulamentação das TNCs

- Percepção acerca das TNCs enquanto profissões (i.e. com sistema de qualificações profissionais, associações e corpos profissionais, códigos de conduta, demarcação dos amadores, etc);
- Opinião/ponto de vista acerca da importância das TNCs enquanto profissões;
- Opinião/ponto de vista acerca da aptidão das TNCs para entrar no campo profissional;
- Opinião/ponto de vista acerca do papel do estado e das agências supra-estatais relativamente às TNCs;
- Opinião/ponto de vista acerca da regulamentação de seis específicas TNCs em Portugal;
- Opinião/ponto de vista acerca do impacto da regulamentação das TNCs na profissão e prática médica, nas TNCs como um todo e na sua terapêutica em particular;

3. Estratégias para ganhar status/poder dentro do sistema de saúde

- Definições de prática médica ortodoxa e não ortodoxa;
- Opinião/ponto de vista acerca do papel das TNCs enquanto práticas alternativas e/ou complementares;
- Percepções acerca das diferenças entre ser profissional das TNCs e médico;
- Opinião/ponto de vista acerca do uso e eficácia das TNCs;
- Opinião/ponto de vista acerca da importância da relação profissional entre profissionais das TNCs e médicos;

4. Desafios profissionais colocados pelas TNCs à profissão médica

- Aspectos menos satisfatórios da prática médica e dos cuidados médicos ortodoxos;
- Aspectos das TNCs que poderão ser uma mais-valia e ajudar a melhorar os serviços de saúde;
- Opinião/ponto de vista acerca da posição futura das TNCs no sistema de saúde português;
- Opinião/ponto de vista acerca do nível de desafio profissional colocado pelas TNCs à profissão médica;

5. Relações intra-profissionais

- Percepções acerca das TNCs enquanto grupos profissionais e com uma

- identidade colectiva;
- Percepções acerca da posição das TNCs enquanto grupo profissional face à regulamentação e profissionalização das TNCs;
- Opinião/ponto de vista acerca da relação futura entre as várias terapêuticas não convencionais;

6. Razões porque escolheu a TNC que pratica

- Razões porque escolheu especializar-se na sua área profissional;

Dados biográficos

Data

Sexo

Idade

Modalidade de TNC praticada

Anos de prática profissional na área

**CAM's CHANGING RELATIONSHIP WITH THE
MEDICAL PROFESSION AND THE STATE IN PORTUGAL**

***Orthodox Medical Doctors' Interview Topic Guide
(GPs, Surgeons, Medical Acupuncturists and Medical Homeopaths)
(English Version)***

1. Approaching the topic

- Awareness of the increasing use of CAM therapies, worldwide and in Portugal in particular;

2. CAM professionalisation and regulation

- Orthodox medical doctors' views of CAM therapies as professions (i.e. with autonomy, formal qualifications, professional bodies or associations, codes of ethics, demarcation from the amateurs, etc.);
- Orthodox medical doctors' views on the importance of CAM therapies as professions;
- Orthodox medical doctors' views on the ability of CAM therapies to become professions;
- Orthodox medical doctors' views on the role of the State and supranational agencies in relation to CAM;
- Orthodox medical doctors' views on the regulation of six specific CAM therapies in Portugal;
- Orthodox medical doctors' views on the impact of CAM regulation on the medical profession and medical practice, on their medical speciality in particular and on CAM as a whole occupational group;

3. Strategies to maintain status/power within mainstream healthcare

- Orthodox medical doctors' definitions of orthodox and unorthodox medical practice;
- Orthodox medical doctors' perceptions about being a physician and a CAM practitioner;
- Orthodox medical doctors' views on the use and efficacy of CAM;
- Orthodox medical doctors' views on the role of CAM therapies as complementary or/and alternative practices;
- Orthodox medical doctors' views on their relationship with CAM and CAM practitioners;

4. CAM challenges to the medical profession

- Orthodox medical doctors' views on the less satisfactory aspects of mainstream healthcare;
- Orthodox medical doctors' views on the role of CAM to improve the healthcare services;
- Orthodox medical doctors' views on the importance of talking with their patients about CAM;
- Orthodox medical doctors' views on, and reasons for, (not) referring CAM to their patients;

- Personal and professional uses of CAM by orthodox medical doctors;
- Orthodox medical doctors' views on acquiring training in CAM;
- Orthodox medical doctors' views on the future status of CAM within mainstream healthcare;
- Orthodox medical doctors' views on the challenges of CAM to the medical profession;

5. Intra-occupational relationships

- Orthodox medical doctors' views on the medical profession as a whole professional group;
- Orthodox medical doctors' views on the Portuguese Medical Council;

6. Reasons for choosing a medical speciality/CAM modality

- Reasons why the physician chose to specialise on their professional area;
- Reasons for having engaged in acupuncture and/or homeopathy;

Biographical data

Date

Sex

Age

Speciality

Years of medical practice

Years of CAM practice

A RELAÇÃO PROFISSIONAL ENTRE A PROFISSÃO MÉDICA E AS TERAPÊUTICAS NÃO CONVENCIONAIS EM PORTUGAL

Guião de Entrevista – Médicos (Clínicos Gerais, Cirurgiões, Médicos Acupunctores e Médicos Homeopatas) (Portuguese Version)

1. Abordagem do tópico

- Percepções acerca das actuais dinâmicas das TNCs no mundo e na sociedade portuguesa em particular;

2. Profissionalização e regulamentação das TNCs

- Opinião/ponto de vista acerca das tentativas das TNCs em se desenvolverem enquanto profissão (i.e. com sistema de qualificações profissionais, associações e corpos profissionais, códigos de conduta, demarcação dos amadores, etc);
- Opinião/ponto de vista acerca da importância das TNCs enquanto profissões;
- Opinião/ponto de vista acerca da aptidão das TNCs para entrar no campo profissional;
- Opinião/ponto de vista acerca do papel do estado e das agências supra-estatais relativamente às TNCs;
- Opinião/ponto de vista acerca da regulamentação de seis específicas TNCs em Portugal;
- Opinião/ponto de vista acerca do impacto da regulamentação das TNCs na profissão e prática médica, nas TNCs como um todo e na sua terapêutica em particular;

3. Estratégias para ganhar status/poder dentro do sistema de saúde

- Definições de prática médica ortodoxa e não ortodoxa;
- Opinião/ponto de vista acerca do uso e eficácia das TNCs;
- Opinião/ponto de vista acerca do papel das TNCs enquanto práticas alternativas e/ou complementares;
- Percepções acerca das diferenças entre ser profissional das TNCs e médico;
- Opinião/ponto de vista acerca da importância da relação profissional entre profissionais das TNCs e médicos;

4. Desafios profissionais colocados pelas TNCs à profissão médica

- Aspectos menos satisfatórios da prática médica e dos cuidados médicos ortodoxos;
- Aspectos das TNCs que poderão ser uma mais-valia e ajudar a melhorar os serviços de saúde;
- Opinião/ponto de vista acerca da importância em falar com os pacientes sobre o uso destas terapêuticas;
- Atitudes face à (não) recomendação das TNCs e razões para essa atitude;
- Recurso pessoal e profissional às TNCs;
- Opinião/ponto de vista acerca da potencial formação em TNCs;

- Opinião/ponto de vista acerca da posição futura das TNCs no sistema de saúde português;
- Opinião/ponto de vista acerca do desafio profissional colocado pelas TNCs à profissão médica;

5. Relações intra-profissionais

- Percepções acerca da profissão médica enquanto grupo profissional coesivo;
- Percepções acerca da Ordem dos Médicos portuguesa;

6. Razões porque escolheu a especialidade médica que pratica

- Razões porque escolheu especializar-se na sua área profissional;
- Razões porque escolheu envolver-se em acupunctura e/ou homeopatia;

Dados biográficos

Data

Sexo

Idade

Anos de prática profissional na área

Especialidade médica

Appendix 6 – List of organisations/associations from which documentary material was collected

Abel Salazar Biomedical Science Institute (Instituto de Ciências Biomédicas Abel Salazar, University of Porto – ICBAS/UP)

Website: http://sigarra.up.pt/icbas/web_page.inicial

Advanced Studies in Naturology (Estudos Avançados de Naturologia – EAN)

Website: <http://ean.pt/>

Chinese Medicine University (Universidade Medicina Chinesa – UMC)

Website: <http://www.umc.pt/>

Consultative Technical Committee on CAM (Comissão Técnica Consultiva das Terapêuticas não Convencionais – CTCTNC)

General Directorate of Health (Direcção-Geral da Saúde – DGS)

Website: <http://www.dgs.pt/>

Graduate School of Traditional Chinese Medicine (Escola Superior de Medicina Tradicional Chinesa – ESMTC)

Website: <http://www.esmtc.pt/>

Hippocrates Institute for Education and Science (Instituto Hipócrates de Ensino e Ciência – IHEC)

Website: <http://institutohipocratesonline.com/>

Homeopathic Society of Portugal (Sociedade Homeopática de Portugal – SHP), whose members are generally medical doctors and allied healthcare professionals

Website: <http://www.homeopatiaportugal.org/>

Lisbon Undergraduate School of Technology and Arts (Escola Superior de Tecnologias e Artes de Lisboa – ESTAL)

Website: <http://www.estal.pt/>

National Council of Naturologists and Specialists of Non-Conventional Therapeutics (Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas não Convencionais – CNNET), whose members are generally non-medically qualified CAM practitioners

Website: <http://www.cnnnet-web.org/>

National Federation of Natural Alternative Medicine's Associations (Federação Nacional de Associações de Medicinas Alternativas Naturais - FENAMAN)

Website: <http://fenaman.pt/>

Portuguese Association of Acupuncture and Related Disciplines (Associação Portuguesa de Acupunctura e Disciplinas Associadas – APA-DA)

Website: <http://www.apa-da.pt/>

Portuguese Association of Homeopathy (Associação Portuguesa de Homeopatia – APH), whose members are generally 'traditional homeopaths'

Website: <http://aphomeopatia.weebly.com/>

Portuguese Medical Council (Ordem dos Médicos Portuguesa – PMC)

Website: <https://www.ordemdosmedicos.pt/>

Portuguese Medical Society of Acupuncture (Sociedade Portuguesa Médica de Acupunctura – S.P.M.A.), whose members are medical doctors

Website: <http://www.spma.pt/>

Portuguese Society of Homeopathy (Sociedade Portuguesa de Homeopatia – SPH), whose members are generally medical doctors, allied healthcare professionals and might have other members without previous biomedical background

Portuguese Assembly of the Republic (Assembleia da República Portuguesa) Website:

<http://www.en.parlamento.pt/>

Professional Association of Acupuncture and Traditional Chinese Medicine (Associação Profissional de Acupunctura e Medicina Tradicional Chinesa - APAMTC)

Website: <http://www.apamtc.org/>

Statistics Portugal Institute (Instituto Nacional de Estatística)

Website: http://www.ine.pt/xportal/xmain?xlang=pt&xpgid=ine_main&xpid=INE

Appendix 7 - List of preliminary codes generated on Atlas.Ti

Code-Filter: All

HU: PhD08March09
File: [C:\Users\Joana\Documents\Scientific Software\ATLAS\TextBank\RHUL\PhD08March09.hpr5]
Edited by: Super
Date/Time: 24-03-09 23:06:15

'Conventional scientific method' vs. 'traditional scientific method'
'Heartsink patients'
'Historic validation' of CAM
'Na ponta do meu bisturi nunca..
'New boundaries': CAM for ill health and medicine for illness
Acupuncture as a regulatory technique
Age
Assessing the differences between CAM practitioners and doctors: the system of knowledge
Assessing the differences between CAM practitioners and doctors: the language level
Assessing the differences between CAM practitioners and doctors: the type of paradigm
Assessing the similarities between CAM practitioners and doctors
Bill 45/2003
Boundary redefinition: delimitation of medicine's jurisdiction
CAM'isation of doctors - a double-side strategy
CAM and its scientific validation
CAM and the media
CAM and orthodox medicine: institutional vs. individual relationship
CAM and residual areas of medical practice
CAM and strategies of inclusion: CAM conventionalisation/distortion
CAM and strategies of inclusion: CAM is mainly regulatory and preventative and consequently, safe
CAM and strategies of inclusion: drawing CAM limits
CAM and strategies of inclusion: getting support from physics to validate theory (homeopathy)
CAM and strategies of inclusion: medical pragmatism/pragmatisation of the healing process
CAM and strategies of inclusion: nós temos métodos de avaliação..
CAM and strategies of inclusion: objectify its 'traditional scientific method'
CAM and strategies of inclusion: Porque depois maus profissiona..
CAM and strategies of inclusion: pragmatic attitude towards the Portuguese CAM Bill
CAM and strategies of inclusion: qualquer doente que eu atendo ..
CAM and strategies of inclusion: recollection of CAM in Eastern countries
CAM and strategies of inclusion: historical similarity between CAM and other established (health) professions
CAM and strategies of inclusion: doctors' personal use of CAM
CAM and strategies of inclusion: rising training and educational standards
CAM and strategies of inclusion: setting up CAM associations
CAM and strategies of inclusion: tolerance towards CAM'isation of doctors but only as a way to get a complementary practice and not a specialisation
CAM and strategies of inclusion: transdisciplinarity
CAM and strategies of inclusion: work in partnership with doctors (in medical settings)
CAM and the Portuguese state: perceptions on the position of the state towards CAM
CAM's diagnosis
CAM's jurisdiction
CAM practitioners' worldviews: holistic socialisation/worldview
CAM practitioners' worldviews: scientific socialisation/worldview
Changing mentalities
Characteristics of CAM
Class differences in the popular use of CAM
Co-operation: among all health professions
Confronting CAM with the medical profession
Current doctor/CAM practitioner relationship: competition and corporative struggle
Current doctor/CAM practitioner relationship: different worldviews
Current doctor/CAM practitioner relationship: fall of medical power
Current doctor/CAM practitioner relationship: lack of information about CAM's professional jurisdiction
Current doctor/CAM practitioner relationship: lack of trust
Defining CAM therapies: as medicine and as techniques/therapeutics
Demarcating CAM from CAM practitioners by using the argument of lack of professionalism, expertise and deficient training
Demarcating CAM from the esoteric

Demarcating CAM from the medical profession: CAM not as a complementary medicine but CAM and orthodox medicine in a complementary process

Demarcating CAM from the medical profession: creating a CAM jurisdiction (acupuncture)

Demarcating CAM from the medical profession: development of specialised knowledge and professional training

Demarcating CAM from the medical profession: holistic paradigm vs. scientific paradigm

Demarcating CAM from the medical profession: stating the lack of medical knowledge/understanding of CAM

Demarcating CAM therapies from other CAM therapies: jurisdictional boundaries

Demarcation homeopathy and acupuncture

Dehumanisation

Developing CAM ethics: awareness of CAM limits/efficacy and CAM jurisdiction (acupuncture)

Developing CAM ethics: Sense of professional responsibility

Developing CAM ethics: set up a consultation model/pattern

Doctors stating acupuncture as one of the more valid CAM therapies

Drawing CAM limits: internal illness and external illness

Escola Superior de Medicina Chinesa (Pedro Choy) e Escola do Atneu (José Faro)

Ethical Commission

Explaining the way the state thinks about health

Explaining the way the state works

Explaining why acupuncture can be an autonomous profession (independent from the medical profession): it has its own methodology

Explaining why acupuncture can be an autonomous profession: Estudei

Explaining why acupuncture can be an autonomous profession: eu sei ver análises clínicas, ..

Explaining why acupuncture can be an autonomous profession: has its own diagnosis

Explaining why acupuncture can be an autonomous profession: it has its own paradigm

Explaining why acupuncture can be an autonomous profession: nós temos uma avaliação muito ..

Explaining why CAM regulation is an aim but also a problem for WHO

GP's own perceptions of their limited experience on CAM

Highlighting the medical power/status/authority/self interests

Homeopathy and homeopathic industry

Homeopathy and orthodox medicine overlap: the pharmaceuticals

Homeopathy and orthodox medicine: the content of abstract knowledge

Homeopathy, homeopaths and 'homeopetas'

Homocentrismo

Impact of a better medical doctor/CAM practitioner relationship on the patient: less money is spent

Impact of a better medical doctor/CAM practitioner relationship on the patient: more efficacy in diagnosis and treatment

Impact of a better medical doctor/CAM practitioner relationship on the patient: the patient gets more satisfied

Impact of a better medical doctor/CAM practitioner relationship: the patient gets more clarified

Impact of CAM regulation on CAM: a gap between regulated and non regulated CAM therapies

Impact of CAM regulation on CAM: open the way for further regulation of other CAM therapies

Impact of CAM regulation on CAM: professional control and supervision

Impact of CAM regulation on CAM: rise of different CAM associations and CAM groups of interest

Impact of CAM regulation on CAM: rise of training and education standards (acupuncture)

Impact of CAM regulation on CAM: uniformisation of training and education (acupuncture)

Impact of CAM regulation on the medical profession: decrease of number of patients

Impact of CAM regulation on the medical profession: fall of salaries

Impact of CAM regulation on the medical profession: loss of status/power/prestige

Impact of CAM regulation on the medical profession: jurisdictional struggle

Impact of CAM regulation on the medical profession: numa primeira fase eu penso qu..

Impact of CAM regulation on the medical profession: readjustment of medical jurisdiction

Impact of CAM regulation on the medical profession: reorganisation of the medical profession

Impact of CAM regulation on the patient: expand patient's medical choices

Impact of CAM regulation on the state: it will lose money

Impact of CAM regulation on the state: problems in the state/medical profession's relationship

Integrative medicine

Intra-occupational differences among acupuncturists: power conflict

Intra-occupational differences among acupuncturists: conflicts over power, interests and credentialism

Intra-occupational differences among acupuncturists: commission on CAM

Intra-occupational differences among acupuncturists: regulation is not wanted by all due to the consequent raise of training and education standards

Intra-occupational differences among acupuncturists: spread of associations

Intra-occupational divergence: lack of professional and ethical trust

Kind of CAM patient/CAM practitioner contract/relationship (CAM/biomedical patient; scientific/holistic practitioner)

Less satisfactory aspects of medicine nowadays: economic exploration and ideology

Less satisfactory aspects of medicine nowadays: fragmentation of patients/patient as a sum of organs

Less satisfactory aspects of medicine nowadays: healthy patient seen as an economic good

Less satisfactory aspects of medicine nowadays: little understanding about what health is

Less satisfactory aspects of medicine nowadays: medication side-effects/iatrogenic effects

Less satisfactory aspects of medicine nowadays: close relationship between medicine and the pharmaceutical industry
 Less satisfactory aspects of medicine nowadays: time of medical consultations
 Less satisfactory aspects of medicine nowadays: close relationship between the Catholic Church and medicine
 Less satisfactory aspects of medicine nowadays: treat the symptom but not the cause
 Less satisfactory aspects of medicine nowadays: underestimation of the symptoms
 Less satisfactory aspects of orthodox medicine nowadays: 'pharmaceuticalisation of society'
 Less satisfactory aspects of orthodox medicine nowadays: consultation prices timetables
 Less satisfactory aspects of orthodox medicine nowadays: lack of affectivity in the doctor/patient relationship
 Less satisfactory aspects of orthodox medicine nowadays: lack of doctor's availability
 Less satisfactory aspects of orthodox medicine nowadays: overspecialisation
 Less satisfactory aspects of orthodox medicine nowadays: depending too much on complementary diagnostic tests and therapy
 Humans only see what they already know
 Marginal status of homeopathy
 Meaning of profession
 Medical Council
 Medical profession's altruism/self-interest
 Medical profession's strategies (institutional level)
 Medical profession and its strategies to maintain power/status: against CAM regulation
 Medical profession and its strategies to maintain power/status: publicise CAM charlatanism and lack of professional ethics
 Medical profession and its strategies to maintain power/status: CAM lacks scientific knowledge
 Medical profession and its strategies to maintain power/status: drawing CAM limits
 Medical profession and its strategies to maintain power/status: use of social/professional taboos
 Medical profession and its strategies to maintain power/status: using placebo effect to explain CAM results
 Medical profession and its strategies to maintain status/power: confronting CAM's results with 'nature' results
 Medical specialities seen as less responsive to CAM: surgeons
 Medical specialities seen as more responsive to CAM: GPs
 Medical specialities seen as more responsive to CAM: neurologists
 Medical specialities seen as more responsive to CAM: odontologists
 Medical specialities seen as more responsive to CAM: orthopaedics
 Medical specialities seen as more responsive to CAM: physiatrist
 Medicalisation of CAM
 Medical jurisdiction
 métodos considerados tradicion..
 na medicina não consigo perceb..
 No differences between specialities
 Over-medication
 Over-specialisation
 Placebo effect as a reasonable healing process
 Pragmatism of medicine
 Pragmatism
 Reason CAM trained/friendly doctors turn to CAM practice: of orthodox treatments are aggressive
 Reason CAM trained/friendly doctors turn to CAM practice: critique of the mechanistic paradigm of medicine
 Reason CAM trained/friendly doctors turn to CAM practice: personal or family successful use of CAM
 Reason for CAM trained/friendly doctors turn to CAM: following the same path as other doctors in other countries
 Reason for CAM trained/friendly doctors turn to CAM: lack of success of some conventional treatments
 Reason for CAM trained/friendly doctors turn to CAM: over-medication/pharmaceuticalisation
 Reason for CAM trained/friendly doctors turn to CAM: seek a different doctor/patient relationship/encounter
 Reason for CAM trained/friendly doctors turn to CAM: seek for a gentle medicine/avoid orthodox treatments side-effects
 Reason for CAM trained/friendly doctors turn to CAM: seek holistic approach
 Reason why CAM trained/friendly doctors turn to CAM practice: a gap in the management of pain
 Reasons to study CAM (acupuncture): curiosity for the philosophical background
 Reasons to study CAM (acupuncture): influenced by someone (a guru)
 Redefinition of medicine's ethics: awareness of medicine's limits
 Special status of acupuncture due to its use of needles
 State of the art of acupuncture: diversity of training/education
 State of the art of acupuncture: lack of a regulatory council
 State of the art of acupuncture: lack of professional control and supervision
 State of the art of acupuncture: lack of vocational test for acupuncturists
 State of the art of acupuncture: não há participações
 State of the art of acupuncture: need to work in a medical setting controlled by a doctor due to economic constraints
 State of the art of homeopathy: lack of trust on its system of (abstract) knowledge
 State of the art of acupuncture: treatments' limitations due to a lack of regulation and professional ethics
 Stating acupuncture is a profession: because has proved methods, strategies and techniques

Stating acupuncture is a profession: because it has a methodology
 Stating acupuncture is a profession: because it has a system of (specialised) knowledge
 Stating acupuncture is a profession: because of its effective outcomes
 Stating acupuncture is a profession: because we can occupy our life with it
 Stating acupuncture is a profession: if rises the quality of training
 Stating acupuncture is a profession: if uniforms education and training
 Stating CAM is sought for every kind of pathology
 Stating changing patterns in health: CAM as a first choice
 Stating increasing popularity of CAM
 Stating lack of public knowledge/understanding about CAM
 Stating the ambiguities of the Portuguese Law created by the Portuguese state
 Stating the commercial side of CAM
 Stating the future of CAM in the Portuguese society
 Stating the lack of quality of CAM products
 Stating the reasons why the Portuguese state is regulating CAM: because of its effective results
 Stating the reasons why the Portuguese state is regulating CAM: European trend
 Stating the reasons why the Portuguese state is regulating CAM: growing number of CAM professionals and the need to regulate them
 Stating the reasons why the Portuguese state is regulating CAM: health quality
 Stating the reasons why the Portuguese state is regulating CAM: is much cheaper
 Stating the reasons why the Portuguese state is regulating CAM: Os seguros já começam a inclui..
 Stating the reasons why the Portuguese state is regulating CAM: popular pressure
 Stating the reasons why the Portuguese state is regulating CAM: their need to be financed
 Stating the reasons why the Portuguese state is regulating CAM: they are acquiring prestige
 Stating the reasons why the Portuguese state is regulating CAM: to avoid charlatanism
 Stating the reasons why the Portuguese state is regulating CAM: WHO advice
 Stating the role of CAM: as a rebalance of health
 Stating the role of CAM: preventative medicine
 Stating the role of CAM: to widen the patient's medical choices
 Stating the self-reflexive self in health
 Stating why these six CAM therapies have been regulated: are the more likely to be accepted by the medical profession
 Stating why these six CAM therapies have been regulated: are the most professionalised
 Stating why these six CAM therapies have been regulated: são as mais conhecidas.
 Stating why these six CAM therapies have been regulated: são as mais generalistas
 Stating why these six CAM therapies have been regulated: são as mais procuradas
 The debate around acupuncture/Traditional Chinese medicine
 There will be space for everyone
 Traditional Chinese Medicines and not Traditional Chinese Medicine
 Vantages of CAM/medical profession partnership: get closer to patients
 WHO
 Years of professional practice

Appendix 8 – Simplified version of the Portuguese legislative process

	PARLIAMENT (Bill Proposal)	New legislation (NL) is proposed by	GOVERNMENT (Bill Project)
		NL is introduced and accepted by the President of parliament	
		NL is referred to a standing Committee (Amendments)	
		Parliamentary debate on the general principles of the NL; vote;	
	NL Approved		NL Rejected
	NL Debated and voted on clause by clause in parliament/standing Committee		
	Final general vote on NL by parliament		
	NL turns an Assembly of the Republic Decree		
	The Decree is sent to the President of the Republic		
Endorsement		Veto	

PUBLISHED ARTICLES

**Teresa Carvalho | Rui Santiago | Telmo Caria
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E SOCIEDADE
DO CONHECIMENTO:
Tendências, Problemas
e Perspectivas**

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Capítulo 7

MEDICINAS ALTERNATIVAS E COMPLEMENTARES E MANOBRAS DE LEGITIMAÇÃO: O CASO DA ACUPUNCTURA E DA HOMEOPATIA EM PORTUGAL

Joana Almeida¹

INTRODUÇÃO

Desde a década de 1970, nos países do Ocidente onde a biomedicina tem monopolizado os serviços de saúde e gozado hegemonia ideológica, tem vindo a assistir-se a um «revivalismo» de práticas de saúde heterodoxas, entre elas as habitualmente designadas por «medicinas alternativas e complementares» (MACs) (Cant & Sharma, 1998). A ideia de que com o seu revivalismo estas medicinas passaram a reivindicar mudanças nos cuidados oficiais de saúde, e a pôr em prática estratégias de legitimação e de fechamento ocupacional, tem sido explorada por vários autores em países como o Reino Unido (Cant, 1996; Cant & Sharma, 1996; Saks, 1995), Holanda (Schepers & Hermans, 1999), Canadá (Boon *et al.*, 2004; Gilmour *et al.*, 2002; Kelner *et al.*, 2006; Wellman *et al.*, 2001; Welsh *et al.*, 2004), Austrália (Baer, 2006), EUA (Baer *et al.*, 1998) e Singapura (Quah, 2003).

Portugal, como constatado por Carapinheiro e Rodrigues (1998), carece de estudos sobre o processo de institucionalização de muitas profissões e sobre as estratégias de legitimação e de fechamento ocupacional desenvolvidas pelos vários grupos ocupacionais. No campo da saúde, o caso das MACs é um excelente exemplo. País onde a ideologia biomédica é a convencional, dominando o sistema oficial de saúde, Portugal tem vindo a assistir, à semelhança de outros países, a uma tentativa de legitimação de algumas destas terapêuticas. Até à data, este processo tem suscitado na sociedade portuguesa pouca reflexão sociológica, pelo que se torna oportuno mapeá-lo sociologicamente.

O presente texto analisa as principais estratégias de legitimação e de fechamento ocupacional utilizadas por duas MACs, acupunctura e homeopatia, ao longo dos últimos 12 anos na sociedade portuguesa. Privilegia estas duas terapêuticas por serem

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paradigmáticas na sua relação com a ortodoxia médica no país: enquanto que a acupuntura tem vindo a ser «integrada» no currículo médico, a homeopatia continua a ser olhada com descrença. Mais, procura inserir-se tais estratégias num processo mais amplo de «MAC'isação», em que diferentes MACs têm procurado «colonizar» o *habitat* biomédico, pressionando-o a aceitar novas regras de conduta, bem como itinerários terapêuticos alternativos.

CONSIDERAÇÕES TEÓRICAS

Utiliza-se aqui como referência teórica uma perspectiva neoWeberiana das profissões. Central a esta perspectiva é a ideia de que os grupos profissionais tendem a utilizar estratégias de fechamento ocupacional nas suas relações de poder com grupos rivais na provisão de trabalho especializado no mercado de trabalho (Collins, 1990; Witz, 1992). Este processo de fechamento ocupacional ou de procura ou manutenção de um «mercado profissional» (Larson, 1977) inclui não apenas estratégias de demarcação e de exclusão através das quais um grupo social dominante – neste caso a profissão médica – procura manter o seu poder e autoridade, mas também estratégias de inclusão e de demarcação, através das quais grupos ocupacionais «marginais» e «excluídos» (Saks, 2003; 1995) – neste caso as MACs – procuram adquirir poder e autoridade. Ou ainda, tal como estudos sociológicos mais recentes na área das MACs têm sugerido, estratégias de «incorporação» (Saks, 1995), de «acomodação» (Callahan, 2002) e «cooptação» (Baer, 2001), através das quais grupos ocupacionais «marginais» são aceites por grupos ocupacionais dominantes, mas numa base de subordinação e incorporados no paradigma ocupacional dominante.

São já vários os estudos sociológicos realizados em contexto internacional que identificam as principais estratégias de fechamento ocupacional e de criação de um «mercado profissional» utilizadas pelas diferentes MACs nas suas relações de poder com a profissão médica e com o próprio Estado. Entre essas estratégias, as de profissionalização têm adquirido um lugar de destaque. Se, na década revivalista de 1970, a reemergência das MACs foi sobretudo de natureza carismática, isto é, propiciada por um conjunto de indivíduos com um poder carismático tal que permitiu a formação de correntes de discípulos que transmitiam os seus conhecimentos de forma individualizada e pouco estruturada, uma década depois, a partir de 1980, tal tendência foi substituída por uma outra, testemunhada pela multiplicação de escolas de formação e associações profissionais, o que resultou na formalização, sistematização e estandarização do saber de grande parte destas terapêuticas (Cant & Sharma, 1996). As escolas de formação levaram à criação de requisitos mínimos de entrada e de requisitos de competência profissional, o que, por sua vez, levou à constituição de currículos estruturados, aspectos que vieram reduzir o facilitismo da entrada nestas terapêuticas.

Este processo de profissionalização das MACs sugere, assim, como nos faz ver Gonçalves (2006) na sua análise dos monopólios profissionais, um «processo de mobi-

lidade colectiva, protagonizado pelos profissionais» bem como uma «transformação dos papéis ocupacionais desempenhados pelos [próprios] profissionais» (p. 18). Por outras palavras, as diferentes MACs, enquanto grupo ocupacional com interesses económicos e sociais colectivos, têm posto em acção estratégias de fechamento ocupacional e de criação de «mercados profissionais». Tais estratégias implicam acções colectivas como as de transformação dos seus papéis ocupacionais através, por exemplo, do aumento do credencialismo, sendo que o seu sucesso está geralmente dependente do reconhecimento e apoio do Estado (Larson, 1977).

Outras análises sociológicas têm-se focado menos nas estratégias de profissionalização e mais nas tentativas das diferentes MACs em compensar os excessos e desequilíbrios da hegemonia biomédica no sistema oficial de saúde nos últimos tempos. A promoção do holismo na saúde e da prevenção da doença têm ocupado um lugar de destaque, embora sejam, a maioria das vezes, aspectos analisados mais enquanto características identitárias das MACs ou como «forças compensadoras» (*countervailing powers*) (Light, 1995) dos desequilíbrios provocados pela biomedicina, e menos enquanto tácticas de legitimação e de demarcação ocupacional. A promoção do holismo na saúde e da prevenção da doença, por exemplo, está fortemente relacionada com os movimentos de contracultura médica emergentes nos anos de 1960/1970, que expressavam desencanto por tudo aquilo que na altura fosse convencional (Goldstein, 1985), apresentando, para isso, «alternativas» de olhar a saúde (de carácter mais holístico e preventivo), principalmente em áreas médicas «residuais» (Abbott, 1988) face às quais a biomedicina oferecia (e continua a oferecer) pouca alternativa.

O objectivo do presente texto é assim o de mapear Portugal na análise das estratégias micro, meso e macro mais proeminentes utilizadas pelas MACs, apresentando como estudo de caso a acupuntura e a homeopatia. Tendo como ponto de partida o contexto português, procura-se, ainda, teorizar sobre o efeito mais alargado que tais estratégias têm procurado obter sob o sistema oficial de saúde e sob o modelo biomédico que lhe está subjacente.

METODOLOGIA

Entre os principais actores deste estudo encontram-se os acupunctores e homeopatas tradicionais em contexto português, *i.e.*, acupunctores e homeopatas sem o curso de medicina e que se intitulam profissionais de uma corrente clássica da acupuntura e da homeopatia porque mais próxima das suas raízes históricas. Contrastam, de certa forma, com os «médicos acupunctores» ou «médicos homeopatas», profissionais com o curso de medicina e a exercer de forma paralela acupuntura ou/e homeopatia geralmente numa versão mais biomedicalizada.

Os resultados empíricos apresentados baseiam-se na análise de conteúdo de entrevistas em profundidade realizadas a 10 acupunctores tradicionais e 10 homeopatas tra-

dicionais, alguns deles escolhidos por também desempenharem, na altura, papéis de liderança no processo de legitimação destas terapêuticas. Trata-se, desta forma, de uma construção da amostra simultaneamente em bola de neve e propositada. As entrevistas foram realizadas em diversos pontos do país entre Março de 2008 e Março de 2009. Juntamente com as entrevistas, foi realizada uma pesquisa documental intensa, nomeadamente a análise de fontes de informação tais como: jornais, revistas, folhas e boletins informativos e documentos institucionais tais como relatórios, pareceres, Leis, Decretos-Lei, Projectos-de-Lei e sessões plenárias do parlamento português, e ainda *websites* de instituições relacionadas com as diferentes MACs.

ACUPUNCTORES E HOMEOPATAS TRADICIONAIS: ESTRATÉGIAS DE LEGITIMAÇÃO E DE FECHAMENTO OCUPACIONAL

O presente texto sugere três estratégias de legitimação e de fechamento ocupacional proeminentes entre os acupunctores e homeopatas tradicionais participantes neste estudo. Elas são: (1) estratégias de compensação, (2) estratégias de profissionalização e (3) alianças estratégicas. Cada uma destas estratégias pode ser vista enquanto manobra de acesso ao poder no campo da saúde em Portugal.

Estratégias de compensação

As estratégias de compensação são aqui entendidas como tácticas que procuram contrabalançar os excessos e desequilíbrios da biomedicina ao longo dos últimos tempos. Por exemplo, entender a saúde e a doença de uma forma holística, promover práticas preventivas da doença e de consciência da saúde, oferecer itinerários terapêuticos alternativos ao biomédico em áreas médicas «residuais» e adoptar uma disposição ou «*ethos* pragmático» (Quah, 2003) no processo de tratamento, são estratégias de compensação que irão desenvolver-se de seguida.

Holismo clínico

A retórica quer de acupunctores, quer de homeopatas tradicionais, foi marcada, com bastante frequência, pelo contraste entre os cuidados holísticos de saúde e os tratamentos reducionistas da doença que os entrevistados afirmaram prevalecer na prática médica em Portugal. Este aspecto é ilustrado pelo seguinte acupunctur, recentemente graduado em acupunctura por uma escola inglesa e a providenciar consultas de acupunctura numa clínica privada no país:

«Se calhar ser terapeuta [acupunctur] hoje em dia é o que era ser médico há cinquenta anos atrás. É conhecermos bem os nossos doentes, é tentarmos perceber o

envolvimento da vida do... da vida do doente na... patologia que ele tem, nos seus hábitos de vida, no seu ambiente, isso tudo... Eh... porque é importante e hoje em dia penso que praticamente ser médico é tratar doenças. Portanto, aí há uma diferença fundamental».

Está subjacente a esta declaração uma concepção de acupuntor definida por contraposição ao médico e ao seu sistema biomédico adjacente. Promover a abordagem holística na saúde, sob jurisdição do acupuntor, pode ser vista enquanto força compensatória da abordagem reducionista, que tem dominado os cuidados oficiais de saúde, onde a ênfase é colocada mais sobre o organismo, o órgão, e menos sobre o indivíduo enquanto pessoa. A abordagem holística da saúde está muito perto daquilo que Guerra e Tomé (1964) definem como medicina social: «consiste em dar o devido relevo aos factores sociais da doença, e por conseguinte, visa estabelecer a conexão entre a doença e o meio. Designa, portanto, uma directriz para a etiologia, diagnóstico, tratamento e recuperação» (p. 629).

A abordagem holística da saúde foi com muita frequência, reclamada juntamente com a ênfase dada à recuperação, aos cuidados restaurativos ou ao «realinhamento» do doente. Tal como um homeopata-líder e representante da *Associação Portuguesa de Homeopatia* (APH) e da *Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas Não Convencionais* (CNNET) (mais à frente apresentada) declarou:

«[Os médicos que] tratem e depois que passem ou passariam para toda uma situação de equilíbrio daquilo que foi desequilibrado e não só. Houve necessidade mas ao fazer uma cirurgia desequilibraram, não é? E por consequência, se desequilibraram, isso pode parecer um paradoxo. Desequilibraram mas reequilibraram. Ajudaram a reequilibrar. E por consequência os cuidados deveriam passar depois para a medicina natural precisamente para haver uma continuidade do bem-estar de pessoas e respeito pelo próprio doente».

Numa primeira análise, esta declaração parece ser muito altruística, procurando legitimar os cuidados restaurativos através dos benefícios para os próprios pacientes. Esta tentativa de legitimação é também evidenciada através da ênfase dada aos desequilíbrios biomédicos, como é o caso da *iatrogenes* (Illich, 1977). Como mencionou Illich, já nos anos de 1970, os efeitos secundários da abordagem científica da saúde têm vindo a aumentar. A acupuntura pode, assim, do ponto de vista de muitos dos participantes, ver-se legitimada se reivindicar jurisdição ou competência profissional para lidar com esses mesmos efeitos, procurando promover a ideia de um realinhamento do doente.

Ainda, a tentativa de legitimação da abordagem holística da saúde encontra-se muito associada ao retorno a uma abordagem humanizada dos cuidados de saúde. Vale a pena apresentar a seguinte declaração de um homeopata tradicional que, antes de se dedicar à homeopatia e à naturopatia, trabalhava para a indústria farmacêutica:

«De todo. De todo, não tenho problema. Desiludiu-me profundamente a desumanização da medicina alopática. Recuso-me determinantemente a olhar para uma pessoa e a vê-la como um lote de análises clínicas, de exames imagiológicos com um diagnóstico e um rótulo. Acho isso de uma soberba brutal. [...] As pessoas viram uma fachada metida numa pasta. Chega ao cúmulo dos alopatas, ao quererem aprofundar, ao quererem ter uma relação com o doente, não poderem, se estiverem numa instituição do Estado. Porquê? Eles hoje são estupidamente rentabilizados pelo tempo que demoram com um doente. Eu invisto tempo com um doente, eu não demoro tempo com um doente».

Esta declaração expressa dois aspectos importantes. Em primeiro lugar, práticas correntes e excessos da biomedicina são estrategicamente mencionados como forma de legitimar a necessidade de humanizar os cuidados de saúde. Desumanização, reducionismo médico, uso excessivo de tecnologias médicas e racionalização das práticas de saúde, são alguns dos temas realçados por este homeopata. Em segundo lugar, constrangimentos impostos pelas políticas de saúde, no país no que respeita à duração das consultas em serviços públicos de saúde tais como centros de saúde, são vistos como desencorajadores da humanização nas relações médico-doente. Sugere-se, assim, que o retorno às relações humanizadas na saúde representa uma estratégia de compensação, uma vez que realça dimensões menosprezadas pela biomedicina e pelos profissionais convencionais de saúde ao longo dos últimos tempos.

Prevenção da doença e consciência da saúde

Apesar da prevenção da doença e da consciência da saúde poderem expressar dimensões de uma prática mais holística, a sua referência constante entre os participantes faz delas duas estratégias de compensação de destaque entre acupunctores e homeopatas tradicionais. Ainda que tendam a permanecer idílicas, uma vez que, tal como é subjacente à declaração de um acupunctur-líder e representante de uma das associações de acupunctura com mais expressão no país – *Associação Profissional de Acupunctura e Medicina Tradicional Chinesa* (APAMTC) –, a prevenção da doença não depende apenas de uma mudança geral de atitudes do paciente e do profissional face à saúde, mas também de factores estruturais, tais como as políticas de regulamentação das MACs, as quais permanecem inacabadas no país:

«E depois, então, daí tem vindo [a acupunctura] a espalhar-se, a espalhar-se, a espalhar-se e hoje realmente já é fácil, já é fácil encontrar isto. Não para fazer aquilo que nós pretendemos né, que é a prevenção... o ideal da Medicina [Tradicional] Chinesa é prevenir, não é tratar. [...] Como ainda não conseguimos ter a tal situação legalizada, portanto, a lei já saiu mas não há regulamentação, o que acontece é que não há participações, não há isto, não há nada, o que leva a que realmente as pessoas não procurem... coitados, só em último caso aparecem para o tratamento. O que é mau».

É feita nesta declaração referência ao Estado como instituição poderosa de legitimação das MACs. O Estado português é aqui referido como pouco encorajador da saúde preventiva. A Medicina Tradicional Chinesa (MTC), da qual a acupunctura faz parte, é estrategicamente legitimada pelos seus poderes mais preventivos do que curativos. Entre outros entrevistados, o crescimento da doença crónica é muitas vezes associado à pouca importância dada à prevenção na saúde. Vale a pena apresentar a declaração de um outro acupuncturista onde se procura compensar o estatuto marginal da medicina dita «preventiva» e onde se sublinha a consciência da saúde como um aspecto encorajador da prevenção:

Ent: «E quando se deve consultar o acupuncturista?»

Acp: «Sempre. Mesmo que não se esteja doente. Especialmente se não se estiver doente. Se não se estiver doente, é nessa altura que a gente deve ir ver o acupuncturista. A Medicina [Tradicional] Chinesa. É esse o grande conselho.»

Itinerários terapêuticos alternativos

Promover abordagens terapêuticas alternativas à abordagem biomédica em áreas médicas «residuais» (Abbott, 1988) foi uma das estratégias de compensação mais referidas pelos participantes deste estudo. Uma das razões por que terapêuticas como a acupunctura têm tomado a dianteira, em muitos dos países ocidentais, relaciona-se com a sua rápida disseminação enquanto alternativa à abordagem biomédica ao controlo da dor, a qual é definida, pela maioria dos participantes, como baseada em fármacos e com uma taxa de sucesso marginal. Neste sentido, promover a ideia de alternativas menos agressivas para o organismo, ou mais «delicadas» do que certas práticas biomédicas, é um claro exemplo de uma tática de compensação e, por sua vez, de legitimação e fechamento ocupacional. Por exemplo, apesar dos acupuncturistas tradicionais neste estudo se mostrarem, de uma forma geral, relutantes em estreitar a esfera de acção da acupunctura a condições específicas, muitas vezes se referiram à paliação como uma das suas principais áreas de intervenção, e o controlo da dor, em casos de reumatologia e lombalgia foi amplamente referido:

«Imagine alguém que tenha uma ciatalgia, uma lombalgia... no hospital vai ter que quê? Fazer análises, vai ter que fazer muitas coisas. Um raio x, um TAC eventualmente, vai tomar um *cocktail* de *Voltaren* e de *Relmus* e muitas outras coisas. E um acupuncturista razoável, pela observação e pela palpação, percebe que aquilo pode ser uma lombalgia ou uma ciática. E com quatro ou cinco agulhas ajuda a pessoa a melhorar. E ao fim de três, quatro dias a pessoa em princípio fica bem».

Apesar da ênfase na paliação, enquanto área de intervenção, foi também referido um conjunto de outras condições para as quais a acupunctura é legitimada como alternativa: infertilidade, enxaquecas, vícios de tabaco, droga ou álcool, depressão e emagrecimento são alguns exemplos:

«A nível da televisão, são sempre os aspectos mais fortes da acupunctura. Especificando, por exemplo, cefaleias, infertilidade, eh... neste momento o auge da acupunctura a nível da comunicação social é a infertilidade. Leva algum tempo mas resulta e bastante por experiência própria. Já engravidei muitas mulheres. [...] Eh... e nas dependências. Toxicodependentes, alcoólatras, doenças mentais, depressões, essencialmente depressões, muitas depressões, aspectos emocionais, anorexia e o auge, o auge neste momento, é emagrecimentos através da acupunctura. Equilibrar o apetite e reduzir com métodos de acupunctura específicos para o emagrecimento. Eh... a acupunctura, em todas as áreas, em todas as áreas, em todas as áreas...»

is, penso eu».

sta participante ter concluído que a acupunctura se estende a todas as áreas, expressou um conjunto de condições que tendem a ser áreas biomédicas vulneráveis, para as quais a biomedicina não tem propriamente soluções. Como Abbott (1988) bem afirmou, as áreas (biomédicas) residuais são as profissões e à apropriação do conhecimento se apresentam também

édica está também presente em muitos domínios do sistema respiratório e doenças médicas mais referidas por serem mais relutantes que os domínios específicos. Para uma abordagem médica significa abordar a área da biomédica. Os profissionais médicos totalmente diferentes do domínio da medicina salientam com frequência a importância de certas condições clínicas:

anti [ênfase minha], contra as armas terapêuticas que havia em algumas situações quando os médicos, não há mais produtos disponíveis anti não resolvem a situação.

ia biomédica, são com frequência. Discursos sobre a natureza da terapêutica biomédica – criticada e oposta à abordagem semelhante». Mais, está a abordagem terapêutica da biomedicina real.

Apesar de áreas clínicas residuais, condições efectivas bastante vulneráveis ao ataque e interferência de outras abordagens interprofissionais, uma vez que o seu diagnóstico e tratamento são vulneráveis.

A tentativa de legitimar abordagens alternativas à biomedicina entre os homeopatas. Problemas de pele e infecções persistem em crianças, por exemplo, são duas das áreas residuais biológicas. Ainda que os homeopatas se tenham mostrado acupunctores em circunscrever a homeopatia a situações clínicas, a grande maioria, promover uma abordagem alternativa à biomedicina através de uma epistemologia acima de tudo contrária à biomedicina. Os homeopatas vêem a homeopatia como um sistema médico biomédico, e uma das formas mais comuns de o legitimar é a inutilidade e a agressividade de certas abordagens biomédicas.

«E depois cansei-me de estudar medicamentos [...]E depois comecei a fazer uma inventariação das doenças em alopatria. Excluindo os antibióticos, que resolvem as doenças, conseguem no seu espectro, destruir as bactérias infecciosas que resolvam situações. Todos os medicamentos que resolvem as doenças. Eles destroem é os sintomas».

A eficácia genuína da biomedicina, bem como a ideologia da biomedicina, são frequentemente criticadas pela maioria dos homeopatas tradicionais. A abordagem invasiva e «anti» da biomedicina são frequentes. A abordagem «contrários são curados por contrários» – é com frequência a abordagem terapêutica homeopática – «semelhantes são tratados por semelhantes» subjacente a este último excerto um questionar da superioridade da biomedicina, sendo referido o antibiótico como a única medida curativa.

Pragmatismo clínico

Quah (2003), no seu estudo de caso da MTC, em Singapura, refere que os profissionais desta terapêutica tendem a adoptar um «*ethos* pragmático» no processo de cura, representando isso uma resposta temporária à incompatibilidade desta terapêutica com o *ethos* da ciência. Adoptar um *ethos* pragmático face à cura significa legitimar um ponto de vista onde a cura pode ser obtida muitas das vezes através de métodos pouco informados pela evidência científica. Este aspecto é bem ilustrado por um acupunctur tradicional-líder e representante da APAMTC que sugere uma «transdisciplinaridade clínica», a qual define do seguinte modo:

«A medicina para mim é a capacidade de utilizando uma técnica seja ela qual for, seja ela a *dançar à volta do indivíduo* [ênfase minha], que produza um determinado efeito. É a cura. Ou a cura ou a melhora do indivíduo. Portanto, isso é que é a medicina. Portanto, é-me absolutamente indiferente que seja a homeopatia ou que seja isto ou que seja a interligação, e eu sou um homem da transdisciplinaridade, para além... [...] Epá, se um tipo gosta de se *exibir religiosamente dando cambalhotas* [ênfase minha], qual é o problema? Está contente, que dê cambalhotas. Portanto, é absolutamente indiferente, isso».

Este último segmento ilustra bem a natureza explorativa do discurso deste acupunctur. O discurso hiperbólico elaborado à volta dos métodos de «cura» procura legitimar um acentuado pragmatismo clínico onde a importância de atingir um fim (a cura ou a melhora do paciente) é exacerbada, enquanto que a restrição dos meios para atingir esse mesmo fim é alargada a outras abordagens que não apenas as cientificamente informadas. Como referiu um acupunctur tradicional: «nós fazemos a prova pelo resultado».

Associados a este pragmatismo clínico estão também aspectos como a intuição clínica, o carisma e o «dom para», vistos por grande parte dos participantes como desempenhando um papel fundamental no processo de cura. A intuição clínica é muito associada ao «saber carismático», isto é, aquele saber adquirido através da experiência e das virtudes do profissional (Jamous & Peloille, 1970), neste caso do próprio acupunctur ou homeopata tradicional. Ter intuição significa também ter o dom para desempenhar determinada tarefa, neste caso acupuntura ou homeopatia:

«Há terapeutas que de facto têm um *feeling* fantástico e outros não. Ou seja, é importante ser-se razoavelmente técnico e conhecer as regras mas eu acho que é muito mais importante ser-se informado, atento, pronto... isto de facto é subjectivo. É muito subjectivo. E acho que conseguimos esta capacidade pela experiência».

A presença de um pragmatismo clínico entre os participantes identifica-se, ainda, na ênfase dada à evidência baseada na tradição histórica destas terapêuticas, em detrimento da evidência científica:

«Portanto, há terapêuticas que duram, digamos, que têm um percurso de 2 ou 3 mil anos ou 4, não é, para não lhe complicar a vida, no mínimo 2 mil anos, no mínimo... digamos, que trataram biliões de pessoas, biliões literalmente de pessoas, que funcionaram com biliões de pessoas ao longo de centenas e centenas de anos, portanto, não sei o que é que a gente está aqui a discutir. Se funciona ou não».

Está exposta aqui uma evidência e uma justificação da eficácia da acupunctura através da sua longa história. A retórica sobre a tradição milenar da acupunctura foi utilizada por grande parte dos acupunctores tradicionais, neste estudo para justificar a eficácia desta terapêutica. Este mesmo acupunctur tradicional refere-se à tradição histórica da acupunctura como sendo a «evidência científica» dos resultados desta terapêutica: «Mas isso [a acupunctura] está cientificamente provado numa abordagem científica feita de outra forma».

ESTRATÉGIAS DE PROFISSIONALIZAÇÃO

Este estudo identificou um conjunto de estratégias de profissionalização postas em acção por acupunctores e homeopatas tradicionais que importa aqui referir. Tal como já foi mencionado, este tipo de estratégias está claramente associado à tentativa de grupos profissionais obterem legitimação e fechamento ocupacional no mercado de trabalho, a maioria das vezes através da obtenção de credencialismo, *i.e.*, de «peritagem» cognitiva, e do reconhecimento e apoio do Estado. A procura de regulamentação, a demarcação face ao charlatanismo e ao próprio saber biomédico, e a aquisição de credencialismo «ocupacional» e «institucional» (Freidson, 1986) e de coesão de grupo, foram algumas estratégias de profissionalização proeminentes entre acupunctores e homeopatas tradicionais. Analisa-se de seguida cada uma delas.

Apoio estatal

Uma das estratégias de profissionalização das MACs mais evidentes no país, tem sido a tentativa de obter regulamentação estatutária, de forma a dignificar a prática das MACs na sociedade e no sistema de saúde. Após um debate governamental aceso que se estendeu por um período de quatro anos, em 15 de Julho de 2003, o parlamento português aprovou uma Lei (n.º 45/2003 – *Lei do Enquadramento Base das Terapêuticas Não Convencionais*) regulamentadora de seis MACs: acupunctura, homeopatia, osteopatia, quiropráxia, naturopatia e fitoterapia. Em Maio de 2004, por sua vez, foi aprovada a criação de uma Comissão Técnica Consultiva com o objectivo de «[...] estudar e propor os parâmetros gerais de regulamentação do exercício das *Terapêuticas Não Convencionais* [ênfase minha]» (Assembleia da República Portuguesa: 5391), designação dada às MACs em contexto político nacional. Isto significa que a Comissão foi a

entidade responsável por implementar «[...] o processo de credenciação, formação e certificação dos respectivos profissionais das Terapêuticas Não Convencionais» (*ibid.*). A frequente falta de consenso entre os seus diversos membros levou a que fossem necessários quase quatro anos para que a Comissão submetesse as suas propostas à Direção Geral de Saúde (DGS), a qual, embora tenha colocado os textos finais em discussão pública, tem vindo a demonstrar morosidade no processo de regulamentação. Apesar de todo este avanço, até ao momento, as MACs não se encontram regulamentadas, mantendo assim o seu estatuto marginal e a sua tolerância pelo Estado português.

Demarcação face ao saber biomédico

Este estudo identificou, com significativa evidência, retóricas de demarcação dos participantes face aos profissionais médicos e ao saber biomédico a eles associado. Quando questionado sobre a proliferação de médicos convencionais a praticar homeopatia no país, um homeopata-líder no processo de regulamentação das MACs e representante da *Federação Nacional de Associações de Medicinas Alternativas Naturais* (FENAMAN) afirmou o seguinte:

«Há uma falha nessa homeopatia [praticada por médicos], porque o médico que vai para homeopatia, por muito bom que ele queira ser, ele tem um estigma chamado medicina. Então ele aprendeu uma arte de curar que não tem nada a ver com as outras áreas. Eles [os médicos] terem conhecimento e terem alguma noção do que é o remédio e aplicar... tudo bem. Mas não é homeopatia. A homeopatia não funciona com o fundamento científico da medicina, transportá-la para um estudo homeopático. Porque o doente é visto de uma maneira completamente diferente. Eles [os médicos] estão a trabalhar a *homeopatia sintomática* [ênfase minha] e não do semelhante, a lei dos semelhantes. Eles estão lá agora a se preocupar qual é a tipologia da pessoa».

Está neste excerto exposta uma demarcação do uso biomédico da homeopatia, onde se declara que os «médicos homeopatas», *i.e.*, médicos convencionais que praticam homeopatia no país, seguem, a maioria das vezes, uma «abordagem sintomática» desta terapêutica. Noutros termos, o uso biomédico da homeopatia tende aqui a ser visto como reducionista porque focado em identificar e tratar sintomas através de protocolos, desvigorando e distanciando-se, assim, da epistemologia homeopática e da sua ênfase no carácter idiossincrático do paciente e do processo de tratamento. Da mesma forma, também entre os acupunctores se fala de uma «acupuntura sintomática»:

«Olhe, um acupunctur tradicional... ponha ao contrário... um *acupunctur sintomático* [ênfase minha] tem uma formação que até pode ser longa, mas habituam-se a... a tratar com protocolos. Ou seja, se uma pessoa tiver uma alergia, uma renite, uma hérnia discal, tem uma receita. Pica isto, isto e isto. Isto é o que faz a *acupuntura sintomática* [ênfase minha]».

Para este acupuntor, «acupunctores sintomáticos» incluem «médicos acupunctores», isto é, médicos convencionais que praticam acupuntura, mas também, e curiosamente, acupunctores tradicionais «biomedicalizados», isto é, «convertidos» ao discurso biomédico que «ouvem sintomas e criam um protocolo de tratamento» (Acupuntor tradicional). A demarcação face ao saber biomédico é reforçada pelo sentimento recorrente entre os entrevistados de estarem a ser vítimas da invasão dos médicos e de outros profissionais de saúde. Como afirmou um acupuntor tradicional-líder:

«Depois aparece outra coisa. Aparecem os médicos convencionais. Aparecem enfermeiros, aparecem sei lá o quê... massagistas e não sei quanto... todos eles com a agulha na mão a porem agulhinhas. No caso da acupuntura é evidente que há uma reacção por parte dos acupunctores em relação a isso. Então mas como é que é? Então andamos 5 anos, fizemos estágios, estudámos que nem uns... 5 anos com 5 mil horas e não sei quê... e depois aparece o outro a dizer que também é acupuntor e põe as agulhinhas na mesma? Mas como é que é?»

Este excerto ilustra a ideia generalizada entre os participantes de que o uso crescente da acupuntura e da homeopatia por médicos e outros profissionais de saúde tais como enfermeiros, massagistas, psicólogos e fisioterapeutas, é uma usurpação do seu saber. Mais uma vez, o uso biomédico das MACs surge como deficiente e as qualificações dos profissionais biomédicos para as praticar como limitativas, em oposição às qualificações dos próprios acupunctores e homeopatas tradicionais, que utilizam uma abordagem mais clássica destas terapêuticas e que consideram ser a legítima.

Demarcação face ao charlatanismo

As estratégias de demarcação relativamente ao saber biomédico surgiram frequentemente associadas às estratégias de demarcação face ao charlatanismo existente no interior da própria acupuntura e homeopatia. A posição de um acupuntor-líder e representante da APAMTC, ilustra bem esta demarcação:

«Para uma pessoa se formar numa das vertentes médicas não convencionais [nas MACs] leva tempo. Leva tempo. Claro que há exploradores. Como há exploradores, aproveitam-se. Como se aproveitam, fazem uma formação mínima. Depois, claro... os próprios profissionais, não são profissionais, são por exemplo bancários que à noite depois dão umas picadelas no caso da medicina não convencional, ou que receitam umas coisas depois de saírem do emprego e por aí fora. Portanto, não é levado a sério, pronto. E isso é explorado também e bem pela Ordem dos Médicos. A Ordem explora tudo o que pode explorar em relação a estes comportamentos. Pronto, não cabe na cabeça de ninguém que eu seja bancário, esteja por detrás do balcão o dia inteiro e que há noite saia dali, vá para um gabinete e a dizer que faço acupuntura. Mas como é que é? É acupuntor, é bancário ou é isto ou é aquilo?»

A partir deste testemunho percebe-se a fraca coesão observada entre acupunctores (e homeopatas) tradicionais em Portugal. Por exemplo, constatou-se a existência de conflitos internos entre as várias associações e escolas homeopáticas e de acupuntura no país. O mesmo entrevistado, quando questionado sobre as qualificações dos acupunctores no país para diagnosticar², destacou a tensão institucional existente no interior desta terapêutica:

Acp: «Os profissionais sim [têm qualificações para diagnosticar]».

Ent: «E quais são os profissionais?»

Acp: «São aqueles que... neste momento que passaram pela *Escola Superior de Medicina Tradicional Chinesa* [ESMTC]. Não há mais nenhuns. Ah... e depois há os estrangeiros e isso tudo. Há uma quantidade de gente com formação. Eu sou amigo de um dos mestres, que é o [nome do amigo], que é francês, sou amigo dele, é dos melhores, e há outros... pronto. E que realmente de vez em quando vem a Portugal. E depois há gente com formação em Inglaterra, por exemplo».

A reivindicação de direitos sobre o credencialismo da MTC no país é predominante no testemunho deste participante. A ESMTC está entre as escolas a oferecer graduação em acupuntura mais populares e reconhecidas no seio da comunidade de acupunctores no país. Encontra-se intimamente associada à APAMTC. Embora exista uma variedade de associações e de escolas de acupuntura por todo o país, a ESMTC confronta-se com uma outra no mercado, também ela com poder e reivindicação de direitos sob o credencialismo da MTC, a saber, a *Escola Superior de Medicina Chinesa Dr. Pedro Choy*, intimamente associada à *Associação Portuguesa de Acupuntura e Disciplinas Associadas* (APA-DA) da qual Pedro Choy é presidente. Os «estrangeiros» surgiram muitas vezes mencionados sob a forma de gurus ou mestres com elevada experiência e saber carismático numa ou noutra forma de MAC. Profissionais que adquiriram qualificação em MTC em países «credenciados» para tal, como é o caso de Inglaterra, país de eleição de muitos daqueles que procuram formação em acupuntura e homeopatia, são também aqui legitimados.

Aquisição de credencialismo

As estratégias de demarcação em relação à biomedicina e ao charlatanismo surgiram intimamente associadas à aquisição de credencialismo, o qual tendeu a aumentar no país, em particular após a aprovação da Lei 45/2003. No caso da homeopatia, tal como um homeopata-líder e representante da escola *Estudos Avançados de Naturologia* comentou:

Ent: «Qual é a melhor forma de neste momento se saber se um profissional é credível ou não?»

(2) De acordo com o paradigma da MTC.

Hpt: «É pedir-lhe, realmente, aonde é que ele se formou. Pedir-lhe as credenciais que ele tem, se tem carteira profissional... primeiro se tem um curso de formação, quantas horas tem, quem foram os seus professores. E depois se está inscrito em alguma Federação ou alguma Câmara³ que possa avaliar enfim a sua actividade profissional. Porque mesmo que... qualquer profissional para poder exercer tem de ter uma formação e tem de ser acreditado perante uma associação, ou perante uma federação, ou perante o sindicato, ou perante alguma instituição, digamos, corporativa. Eu não gosto de falar da palavra corporativa mas... profissional. Portanto, terá que se pedir a essas pessoas qual é a sua formação».

O excerto apresentado ilustra o crescente desejo dos homeopatas tradicionais em adquirir coesão e identidade de grupo através da pertença a instituições, como é o caso da FENAMAN ou da CNNET, esta última fundada em 2005 e com claras ambições de natureza regulatória, protectora e disciplinadora dos «especialistas das terapêuticas não convencionais». Alguns dos membros da CNNET encontram-se também associados ao *Curso Geral em Terapêuticas Não Convencionais*, iniciado no ano de 2007 na *Escola Superior de Tecnologias e Artes de Lisboa* (ESTAL) um dos cursos mais recentes e pós Lei 45/2003 que procura uma articulação com a própria Lei:

«[A ESTAL procura] conferir competências em terapêuticas não convencionais» e «[...] garante a certificação profissional para o exercício da prática clínica nas opções definidas, consignadas na Lei n.º 45/2003 – Homeopatia; Naturopatia/Fitoterapia; Osteopatia/Quiropráxia; Acupunctura»⁴.

Um elevado número de homeopatas tradicionais revelou um forte desejo em homogeneizar a educação em homeopatia, em parte devido ao estigma de serem vistos como charlatães por grande parte da comunidade médica no país. Apesar do credencialismo em homeopatia ter vindo a aumentar no país, alguns homeopatas, geralmente pertencentes a gerações mais velhas, afirmaram ter obtido credencialismo no estrangeiro, em países como por exemplo a Inglaterra:

«Desde 1980 mais ou menos que eu uso homeopatia. Mas digamos que um estudo aprofundado, não há dúvida nenhuma que a faculdade de homeopatia de Londres [The Society of Homeopaths], pela forma sistemática como estuda os assuntos, foi para mim um grande salto qualitativo na homeopatia».

No caso da acupunctura, Inglaterra, França e China são os países eleitos pelos participantes com mais anos dedicados a esta terapia, sendo que os restantes dividem-se por outros cursos no país, nomeadamente os de duas escolas rivais já referidas: a

(3) O entrevistado refere-se aqui à já mencionada CNNET.

(4) In http://www.estal.pt/site/index.php?option=com_content&task=view&id=80&Itemid=137 (página acedida em Outubro 2010)

ESMTC e a *Escola Superior de Medicina Chinesa Dr. Pedro Choy*. A primeira escola afirma oferecer acesso ao diploma de licenciatura, mestrado e doutoramento da *Universidade de Medicina Chinesa* de Nanjing na China. A segunda escola, por sua vez, reivindica ser o «[...] único curso que permite estudar Acupunctura e Medicina Chinesa em Portugal, seguindo o método e a supervisão de académicos e clínicos chineses»⁵. Esta e outras fragmentações de carácter institucional questionam a existência de uma coesão interna entre os acupunctores e homeopatas tradicionais em Portugal.

Alianças estratégicas

A formação de alianças é aqui definida como uma estratégia utilizada pelas MACs de forma a fomentar a relação com o *habitat* biomédico com o fim de aumentarem a sua credibilidade e de se integrarem, mais facilmente, nos cuidados oficiais de saúde. Identificam-se, de seguida, discursos quer de acupunctores, quer de homeopatas tradicionais, que indicam um número interessante de tentativas de formação de alianças com o *habitat* biomédico, tais como (1) transferência de saber biomédico, (2) promoção da «medicina integrativa» e (3) fomentação das relações profissionais com os médicos.

Transferência de saber biomédico

Apesar da tentativa de demarcação do saber biomédico atrás mencionada, foi frequente identificar uma retórica comum entre acupunctores e homeopatas tradicionais, que sugere uma transferência de aspectos que caracterizam fortemente o saber biomédico para fins de aquisição de legitimidade. Para ilustrar esta ideia escolheu-se a posição de um homeopata-líder que, claramente, utiliza o saber biomédico para legitimar a homeopatia em Portugal:

«É assim, a homeopatia não precisa... vou ser sincero consigo... a homeopatia... há duas vertentes... eu defendo duas vertentes. Eu tenho que defender a parte de ensino, mas a homeopatia não precisa de medicina para nada... de cadeiras médicas para nada. A homeopatia é uma ciência totalmente diferente. Mas depende dos países e depende do público, percebe? Portanto, em Portugal a homeopatia precisava sempre de cadeiras médicas».

Está subjacente, nesta declaração, a importância atribuída à transferência de «cadeiras médicas», *i.e.*, de credencialismo ou saber biomédico, para o ensino da homeopatia, de forma a consolidar alianças com actores influentes na legitimação desta terapêutica (e das MACs em geral), como o caso do público, da profissão médica ou do

(5) In homepage da Universidade Medicina chinesa http://www.umc.pt/index.php?option=com_content&view=article&id=47&Itemid=56 (página acedida em Outubro 2010)

Estado. Grande parte dos participantes, ainda que lute por uma demarcação do saber biomédico, reconhece, também, que a apropriação de algum desse saber ajudará a atingir um melhor estatuto num país onde a profissão médica tem um papel dominante e influente no sistema oficial de saúde (Carapinheiro & Rodrigues, 1998), bem como entre o próprio público (Cabral *et al.*, 2002).

A transferência de saber biomédico traduz-se, também, na cedência às imposições da evidência científica. Ceder à evidência científica foi vista, pela maioria dos acupunctores e homeopatas tradicionais, como uma forma de lidar com as pressões governamentais e supragovernamentais e de obter legitimação. O desejo de evidência científica, por sua vez, sugeriu, muitas vezes, ser uma reacção à denegrição de imagem das MACs, em geral, feita pela ortodoxia médica. A seguinte declaração ilustra a ironia de um homeopata tradicional ao referir-se à importância da evidência científica:

Ent: «E acha que é importante haver essa evidência?»

Hpt: «Acho, acho que sim. Para acabar com esta situação. Somos charlatães».

Tal como o saber biomédico, a prática baseada na evidência não parece desempenhar um papel proeminente entre os participantes, embora seja vista, principalmente por aqueles com funções de liderança, como uma estratégia poderosa para adquirir credibilidade, legitimação e fechamento ocupacional. A transferência de saber biomédico foi, ainda, identificada na retórica de vários participantes através do uso de gíria biomédica:

«A dor de cabeça... é uma migreia, não é uma cefaleia comum. Ok. Dou-lhe um anti-inflamatório não esteróide ou então dou-lhe um antimigranoso de capacidade duvidosa. Os antimigranosos, mais de 50% têm uma taxa de insucesso. Quase a caírem nos sucessos do placebo, que tem um sucesso de 30%. A memória da água tem 30% como tem um antimigranoso».

Ao adquirir e exhibir gíria biomédica, os acupunctores e homeopatas tradicionais estão a manejar instrumentos conceptuais próprios do discurso biomédico e a transferir, assim, aspectos relacionados com o saber biomédico. Mais, a aquisição e exibição de gíria biomédica, tal como a transferência de credencialismo biomédico, devido ao seu forte poder simbólico, procura consolidar alianças com o público, com a própria ortodoxia médica e com o próprio Estado.

Promover a medicina integrativa

Antunes (2003: 95), num artigo sobre a profissão de médico, afirma o seguinte: «Em relação especificamente ao «acto médico», é cada vez mais difícil definir com precisão as fronteiras de intervenção no tratamento de um doente. Mais proveitoso é defender o conceito de equipa e de partilha harmónica, inteligente e construtiva de responsabilidades». Esta última frase espelha, talvez, a forma de legitimação da

«medicina integrativa» idealizada por muitos dos acupunctores e homeopatas tradicionais neste estudo. De acordo com Wiese *et al.* (2010), a medicina integrativa, na sua forma ideal, refere-se ao processo de colaboração e de respeito mútuo entre os diferentes sistemas de medicina. Este ponto de vista é claramente ilustrado pelo seguinte acupunctur tradicional-líder:

«E portanto... e nós também os procuramos [os médicos]. Porque são complementares e volto àquilo que disse no princípio da entrevista... portanto, em que realmente medicina há uma e depois há vários vectores, várias componentes, várias aproximações. E todas elas são válidas. São todas válidas. Quer dizer, não há nenhuma que seja melhor que a outra para mim. Portanto, são todas complementares. Depois tem é de se ter a noção desta transdisciplinaridade, e se não se tem, se não se tem, então não há medicina».

A nível internacional, sucedem-se os estudos sobre as relações profissionais entre médicos e terapeutas das MACs em espaços onde se procura praticar uma «medicina integrativa», tal como é o caso de clínicas integrativas ou espaços integrativos no interior dos hospitais. Tais estudos têm concluído que tal «integração» tem sido difícil de conseguir e que os terapeutas das MACs são, geralmente, marginalizados (Hollenberg, 2006; Shuval *et al.*, 2002). Em Portugal, a acupuntura pratica-se em alguns hospitais públicos do país, ainda que apenas por profissionais médicos e a maioria das vezes limitada ao controlo da dor. Embora vários participantes tenham declarado já ter trabalhado, ou trabalharem, num espaço multidisciplinar, juntamente com médicos, alguns desses discursos espelham os conflitos inerentes a essas colaborações. A este respeito, um acupunctur tradicional contou a sua história:

«Aliás nessa altura eu trabalhava numa clínica em [nome do local], em que havia um médico que era o director clínico, havia eu como acupunctur [tradicional] e havia mais um ou dois profissionais noutra área. Entretanto o médico zangou-se com o dono, apresentou queixa na Ordem... por interesses comerciais... e pronto, depois aquilo embrulhou-se e eu andei embrulhado durante seis, sete anos, acusado do exercício ilegal de medicina, usurpação de funções... aquelas coisas clássicas».

Fomentar relações de «afinidade» com os médicos

Tratar médicos e estabelecer com eles relações de empatia, de afinidade e de cooperação são tentativas de formação de alianças várias vezes referidas por muitos acupunctores e homeopatas tradicionais, tal como se observa na declaração de um acupunctur tradicional:

«Eu cada vez mais tenho encontrado médicos abertos e... tenho variadíssimos pacientes que me são enviados por médicos, tenho vários médicos como pacientes, tenho vários familiares de médicos como pacientes... Pronto, isso eventualmente tem

a ver obviamente com uma questão pessoal em função de, digamos, do resultado e do tipo de trabalho individual de cada um, não é? Mas hoje em dia é de certa forma corrente haver muitos médicos que mandam pessoas ou sugerem as pessoas fazerem um determinado tipo de terapêutica que não está englobada dentro daquilo que é a medicina tal como nós a entendemos, não é?»

Está subjacente a esta declaração a ideia de que as relações profissionais com os médicos são, a maioria das vezes, fomentadas a um nível micro, isto é, fruto das trajectórias pessoais e profissionais dos próprios médicos e das suas interações pessoais com o mundo das MACs, e dependentes de factores contextuais como «afinidade» (Lerner, 2008) entre médicos e terapeutas das MACs.

As relações entre as MACs e a biomedicina estabelecidas a um nível micro contrastam com as relações estabelecidas a um nível mais institucional, as quais permanecem incipientes no país. A seguinte declaração de um homeopata-líder, representante da APH, ilustra bem os conflitos presentes na relação entre homeopatas tradicionais e médicos convencionais que praticam homeopatia:

Ent: «Qual é a diferença entre os homeopatas e os médicos homeopatas?»

Hpt: «É uma questão de elitismo, mais nada. Eu conheço médicos homeopatas espectaculares. Médicos, mesmo. Aqui em Portugal. Conheço um argentino, conheço um mexicano, conheço um português, mas... nós não temos... é assim, vamos lá ver uma coisa... nós não temos nada... não nos damos mal com os médicos homeopatas. Não nos damos. Não é essa a questão. A questão é a Ordem dos Médicos. Não é os médicos homeopatas. É a Ordem dos Médicos é que não quer nada connosco e são, enfim... é uma questão só de concorrência. Mais nada».

DISCUSSÃO

Procurou-se, neste artigo, identificar e analisar as principais estratégias de legitimação e de fechamento ocupacional postas em acção por acupunctores e homeopatas tradicionais em contexto português. Verificou-se que as MACs, representadas aqui pela acupunctura e homeopatia, têm sido actores mais (re)activos e influentes do que passivos na sua relação com a ortodoxia médica. A acupunctura e a homeopatia mostraram sinais evidentes de uma tentativa de negociação de poder com a profissão médica em todos os níveis de análise. Estratégias de poder, como as que procuram compensar os excessos e desequilíbrios da biomedicina, ou as que procuram criar alianças estratégicas de forma a penetrar em território biomédico, ilustram tentativas de negociação de micropoder das MACs em relação ao poder biomédico.

O poder institucional das MACs, por outro lado, parece ter vindo a aumentar no país. No caso da acupunctura e da homeopatia, ambas têm desenvolvido estratégias de profissionalização através do aumento do credencialismo e da demarcação do charlata-

nismo e do saber biomédico. Por outro lado, macroestratégias, como a tentativa de integrar as políticas de saúde e de obter regulamentação estatutária, têm sido mais que evidentes, ainda que esta última permaneça um processo inacabado e conflituoso e, talvez por isso, as MACs em geral permaneçam marginalizadas pelo sistema oficial de saúde.

A natureza contraditória das estratégias de ambas as MACs é facilmente percebida através das variações discursivas dos participantes. Por exemplo, se em certos contextos foram realçadas manobras de demarcação do saber e discurso biomédico, noutros foram destacadas alianças estratégicas com esse mesmo saber e discurso. Se em determinados contextos foi salientada a evidência científica das MACs, noutros foi dada ênfase ao «*ethos* pragmático», ao carisma e ao «dom» profissional. Ainda, a legitimação da acupuntura e da homeopatia, enquanto terapêuticas alternativas em determinados contextos, contrasta com a legitimação destas mesmas terapêuticas, enquanto práticas mais abrangentes e úteis em qualquer situação clínica. Se, em certos contextos, a atitude preventiva das MACs foi, muitas vezes, realçada, noutros o que sobressaiu foram os seus poderes curativos. Estes e outros aspectos são sinais evidentes do carácter estratégico das acções dos acupunctores e homeopatas tradicionais neste estudo. Tal objectivo estratégico, apesar de ilustrado por um cenário nacional de acção onde acupunctores e homeopatas tradicionais são protagonistas, não escamoteia o cenário internacional, onde contradições de igual tipo se têm vindo a manifestar.

Os dados apresentados revelam estratégias de compensação, de profissionalização e de incursão utilizadas pela acupuntura e pela homeopatia em Portugal para integrar os cuidados oficiais de saúde, território por excelência da biomedicina. A tentativa de penetrar em domínio biomédico é, por sua vez, complementada por uma tentativa de reconceptualizar os próprios cuidados e políticas oficiais de saúde. Estas dinâmicas sugerem, assim, olhar as MACs enquanto potenciais colonizadoras do território biomédico, *i.e.*, do sistema oficial de cuidados de saúde. Ao se considerar, por exemplo, a definição biológica de colonização, esta representa o processo através do qual as espécies invasoras se integram com sucesso numa nova comunidade. Da mesma forma, na sociologia das MACs, colonização na sua forma idealizada significaria o processo através do qual as diferentes MACs integrariam o território biomédico. Da mesma forma que em Biologia existem espécies invasivas que recorrem a diferentes estratégias para integrar, por vezes forçosamente, uma nova comunidade, na sociologia das MACs as diferentes terapêuticas apresentam-se como actores hostis que utilizam um conjunto de estratégias para colonizar as políticas e os cuidados oficiais de saúde, pressionando actores como o Estado e a profissão médica a aceitar novas regras de conduta e itinerários de tratamento alternativos. Esta potencial colonização de territórios biomédicos pelas MACs pode ser reconceptualizada usando o termo «MAC'isação» (*CAM'isation*) das políticas e dos cuidados de saúde. O termo «MAC'isação» expressa, assim, um processo inacabado derivado de um conjunto de estratégias de nível micro, meso e macro, postas em acção pelas MACs para promoverem os seus tratamentos e soluções na sociedade e para obterem legitimação e fechamento ocupacional.

O presente artigo procurou mostrar como as MACs, nas suas vertentes de acupunctura e homeopatia, têm procurado integrar as políticas e os cuidados de saúde. Dada a posição estrutural marginal que as MACs ocupam, actualmente, entre as profissões de saúde, uma das questões mais pertinentes é saber até que ponto as manobras estratégicas das MACs têm sido desempenhadas com sucesso. Por exemplo, até que ponto se pode falar de uma real colonização da profissão médica, das políticas e dos cuidados oficiais de saúde pela acupunctura e pela homeopatia? Estarão a acupunctura e a homeopatia a desempenhar com sucesso as suas estratégias de poder em contexto português? Qual tem sido o impacto de tais estratégias na profissão médica, no Estado e no sistema oficial de saúde português? Dadas estas questões, considera-se importante e pertinente investir mais na investigação em Sociologia das MACs em contexto português.

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The differential incorporation of CAM into the medical establishment: The case of acupuncture and homeopathy in Portugal

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Abstract

This paper examines the differential incorporation of acupuncture and homeopathy into the medical establishment in Portugal. While the former has been incorporated into the medical establishment, the latter is still banned by the Medical Council, yet remains in practice by medical doctors in the country. Drawing on the insider viewpoints of medical doctors committed to these two therapies, the findings of this paper suggest that the rhetoric of insufficient scientific evidence of homeopathy still prevails within the medical establishment. However, two other factors were emphasised: the medical prejudice or 'resistance to innovation' of the Portuguese Medical Council and the idiosyncrasies of acupuncture and homeopathy, which have made them amenable to biomedicine (or not). This paper argues that the differential responses of the Portuguese medical establishment to acupuncture and homeopathy are due to reasons beyond that given of the medical rhetoric of insufficient scientific evidence for homeopathy, and which extend to issues of professional status and power. This paper suggests that the emerging commercial interest of the pharmaceutical industry in homeopathy's pharmacopeia worldwide could enhance homeopathy's status in the country and could therefore pressurise the medical orthodoxy to redress its position towards this therapy.

KEYWORDS: CAM incorporation; acupuncture; homeopathy; Portugal; sociology

There has been a growing medical interest in complementary and alternative medicine (CAM) in Western countries in recent years (Fulder, 1996). Amongst CAMs, acupuncture and homeopathy have been considered two of the most widespread therapies within mainstream health-care. Despite a continuing medical concern about their efficacy, both have shifted from a position of rejection to one of tolerant acceptance and have subsequently enhanced their status within the medical establishment. Whilst acupuncture has been strategically incorporated into mainstream health-care (Saks, 1995) and co-opted by biomedicine (Baer, 2001), homeopathy has moved to a position of 'enhanced legitimacy' (Cant & Sharma, 1996).

This increasing tendency of medical interest in CAM arrived in Portugal at a later stage than in other countries, at least at a macro-level. Despite the presence of a grassroots medical interest in CAM for a long time in the country, it was only in the beginning of the twenty-first century that the institutional medical interest in

these therapies took form. Acupuncture became the first CAM therapy legitimated by the Medical Council, and it remains the only one legally practised by medical doctors. Conversely, homeopathy is still banned and attacked by the medical establishment, yet is still practised by medical doctors.

Given these present circumstances, it is of interest to account for the differential incorporation of acupuncture and homeopathy into the medical establishment in Portugal. Furthermore, it is useful to reflect on the extent to which Portugal may follow the path of other Western countries. Little has been said about either the status of these two therapies in the country or the reasons for their differential paths towards their medical legitimacy. It is thus timely to gain some insight into such a neglected issue in Portuguese society. Furthermore, sociological research on CAM tends to underestimate issues of internal heterogeneity within CAM, and by doing so fails to account for the differential incorporation of CAM therapies within the medical establishment worldwide.

This paper reflects on the findings of broader research on the relationship between the medical profession, the State and CAM therapies in Portugal at the dawn of the twenty-first century. It examines the reasons for the differential status of acupuncture and homeopathy within the medical establishment in the country on the part of medical doctors committed to these two therapies. This paper adopts an exclusionary social closure perspective, whilst making use of the concept of 'countervailing powers' to explain the differential incorporation of both of these therapies into mainstream health-care. These perspectives will be adopted and discussed in the following section.

THEORETICAL BACKGROUND

Sociological research which draws on social closure theory has suggested that CAM attempts to acquire legitimacy and occupational closure within mainstream health-care have posed particular challenges to biomedical practice (Kelner, Wellman, Boon, & Welsh, 2004; Saks, 2003; Wolpe, 1985). As a response to such challenges, the medical profession has exercised occupational closure through strategies of exclusion and demarcation. 'Tacit incorporation', as defined by Saks (1994, 1995), or 'co-optation', as proposed by Baer (2001), are two predominant conceptualisations of the recent biomedical closure towards CAM. Amongst all of the CAM therapies, acupuncture is often regarded as a paramount example of a CAM therapy that has been incorporated or co-opted by biomedicine. Saks (1994, 1995), for instance, has suggested that the British medical profession has moved from a long-standing position of rejection to a tacit incorporation of acupuncture. In other words, acupuncture has been biomedicalised (Baer, Jen, Tanassi, Tsia, & Wahbeh, 1998) i.e., transformed into a 'biomedical technique' isolated from its wider theoretical framework of Traditional Chinese Medicine, and restricted to areas where conventional medicine has not been very successful (Dew, 2000). Baer (2004), in turn, has portrayed acupuncture in the USA as a professionalised heterodox medical system which has been granted legitimacy, but

at the cost of a subtle process of co-optation or absorption by biomedicine. Similar scenarios can be observed in countries like New Zealand (Dew, 2000), Norway (Norheim & Fønnebo, 1998), Israel (Bernstein & Shuval, 1997), Germany (Frank, 2002; Frank & Stollberg, 2004), Canada (Welsh, Kelner, Wellman, & Boon, 2004), Argentina (Freidin, 2010) and Brazil (Nascimento, 1998).

Sociological research has not been as established on homeopathy as on acupuncture, however, it is apparent that this therapy has achieved higher status within Western mainstream health-care. As Van Haselen (2005, p. 229) has clearly put it, the Western debate on homeopathy has moved from 'should homeopathy be present at all' to 'how homeopathy should be integrated into the medical system as a whole'. Cant and Sharma (1996), for instance, have shown how homeopathy in the UK has moved from a position of marginality to one of 'enhanced legitimacy'. For example, in the UK the *Faculty of Homeopathy*, a professional body for medical doctors and other mainstream health-care professionals, accredits postgraduate training courses in this therapy which are restricted to those professionals.¹ Further, four hospitals provide homeopathic treatments on the NHS² and in 2006 homeopathic over-the-counter remedies for some conditions were made available to the public (Samarasekera, 2007). Outside Europe, in Brazil for instance, homeopathy has been incorporated in the same way as acupuncture, having been a medical speciality since 1980 (Akiyama, 2004). Interestingly, homeopathy was first incorporated in the Brazilian medical establishment, followed by acupuncture fifteen years later (Akiyama, 2004). According to the European Committee for Homeopathy (n.d.), the Medical Councils from countries such as Germany, Switzerland, Austria, Hungary,

¹ Faculty of Homeopathy website. Available at: <http://www.facultyofhomeopathy.org/training> [Date of access: 29.06.2010].

² British Homeopathic Association website. Available at: http://www.britishhomeopathic.org/getting_treatment/service_providers.html [Date of access: 29.06.2010].

Romania and Spain have also recognised the medical practice of homeopathy.

Nevertheless, this making sense of acupuncture and homeopathy by biomedicine has gone hand in hand with the ongoing debate over their scientific evidence-based efficacy. Recent sociological research on the persistence of medical resistance towards CAM often refers to the idea propounded by the medical profession that CAM does not have a scientific evidence-based practice as the most convenient argument to exercise occupational closure (Callahan, 2002; Kelner et al., 2004). This has been particularly illustrated through the case of homeopathy in some Western countries. Even in countries where homeopathy has enhanced its legitimacy, there are periodic resurgences of medical concern about the scientific validation of this therapy, which is seen as being grounded on irrational premises which violate the traditional concept of science (Degele, 2005). This has been evident in the UK, for instance, with the recent publication of the *Science and Technology Committee's Second Evidence Check Report* of homeopathy (House of Commons, 2010) and the subsequent British Medical Association's resurgent concern about the controversial efficacy of this therapy, with propositions to ban it from the National Health Service (NursingTimes.net, 2010) and to label homeopathic remedies as 'placebos' (Devlin, 2010).

Scholars have argued that the medical concern about scientific evidence in CAM has been one of the more effective strategies in achieving occupational demarcation (Gieryn, 1983; Kelner et al., 2004; Lamont & Molnar, 2002; Lee-Treweek, 2005). Gieryn (1983), for instance, has emphasised the extent to which professions within science perform boundary-work by contrasting themselves to non-scientific occupations, portraying the latter as the outsiders and deviant. By doing this, they attempt to maintain their professional autonomy and to protect their authority over scientific research. For instance, if on the one hand biomedicine insists on scientific research on CAM, on the other hand CAM claims a lack of the socioeconomic opportunities for carrying out evidence-based research on its efficacy (Saks, 2001).

On the surface, CAM retains a lower level of scientific evidence and so can be easily excluded from the medical establishment, which is predicated on such evidence. Dew (2001), in turn, has pointed out that the biomedical ideal of scientific based practice is inconsistent with the significant degree of subjectivity, uncertainty and untested basis of much medical practice. Furthermore, he claims that what gets labelled as unorthodox and orthodox at any particular time depends on the prevailing medical ideologies of the time and on the political manoeuvring of the medical profession. Countries like Britain for instance, have incorporated acupuncture and also legitimated lay acupuncturists who have started professional relationships with medical doctors in the private sector (Saks, 2001). In France, in contrast, medically qualified doctors and a few other conventional health-care professionals are the only ones eligible to practise acupuncture and other forms of CAM (Ramsey, 1999). Both models can be interpreted in terms of the medical profession's interests. In countries like France, the medical establishment is clearly attempting to ban lay acupuncturists who present as a potential professional group claiming jurisdiction over this 'ancient technique'. In countries like Britain, a less defensive approach has been taken, with medical doctors incorporating lay acupuncturists through professional collaboration, which can be seen as a strategy to deal with pressures for change, coming from either the public, from CAM stakeholders or even from the State (Saks, 2001).

Indeed, previous research has suggested that biomedical power is not solely justified by biomedicine's scientific evidence and effectiveness (Van Der Geest & Whyte, 1989). Despite being based on 'scientific knowledge', the scientific evidence for such knowledge is not always as value free as it is purported to be. It is 'interpenetrated by scientific pressure groups, professional, and socioeconomic interests' (Degele, 2005, p. 112) which sponsor the dominant ideology of biomedical power. One such stakeholder group is the pharmaceutical industry. Elliott (2004, p. 125), for instance, has suggested that scientific impartiality in biomedicine has been spoilt by the possibility of biomedicine attaining financial

gain in its relationship with the pharmaceutical industry. He reminds us of the pharma's practice of gift giving to medical doctors in order to persuade them to follow a market-oriented prescription. Such economic interests involving medicine are at least a violation of the good moral conduct of medical doctors which goes back to the Hippocratic Oath.

Scholars have also suggested how the pharmaceutical industry has been 'profit' instead of 'scientific' oriented (Law, 2006; Moynihan, 2002; Williams, Gabe, & Davis, 2009) and has targeted markets that lie beyond medicine's control (Williams, Martin, & Gabe, 2011). Law (2006, p. 7), for instance, argues that the big pharma's interests in providing good health is not clinically oriented but rather stimulated by the 'convenience factor' of producing 'drugs that can ease our passage through life with as little discomfort as possible'. He also points out that health has become a commodity where the patient possesses a strong voice. In its relationship with the medical orthodoxy and CAM, for instance, the pharma industry appears to have acted based on its commercial interests. According to Goldstein (2002), pharmaceutical companies had not expressed great enthusiasm for CAM therapies like homeopathy until recently, when the market for homeopathic remedies started enlarging and could therefore no longer be ignored. The pharmaceutical industry is therefore acquiring growing financial interest in homeopathy, as this therapy has stimulated drugs sales (Goldstein, 2002) due in part to its widely adhered to perception as a non-harmful therapy (Miles, 1998). Light's (1995, p. 26) concept of 'countervailing powers' provides a useful insight into the analysis of the relationship between CAM, the medical profession and the pharmaceutical industry. This notion refers to the counter-moves of powerful actors to redress the imbalance of power '[...] in a field where they are inherently interdependent yet distinct'. According to Light (1995), the degree of power held by a stakeholder group in its dispute for legitimacy, status, power, markets and money is dependent on its ability to immaterialise the challenges posed by others. It would therefore be of interest to know, for

instance, whether the emerging interest of the pharmaceutical industry in homeopathy can be sufficient to unbalance its state of power with biomedicine, to enhance the medical status of homeopathy and to make the latter amendable to biomedicine.

It has been argued in this paper that although acupuncture and homeopathy have been capitalised by biomedicine, they remain a concern to medical orthodoxy. Moreover, the biomedical co-optation of homeopathy has been irregular, with resurgent medical concerns about its scientific efficacy. Such a disparity between the incorporation of these two CAM therapies within orthodox medicine precipitates a look at the historical context of these two therapies within Portuguese health-care, and the extent to which each of them has enhanced its status within the medical establishment in the country.

THE HISTORICAL CONTEXT OF ACUPUNCTURE AND HOMEOPATHY WITHIN PORTUGUESE HEALTH-CARE

Despite the traditional rejection by the Medical Council of CAM in general, there has always been medical enthusiasm in one form or another for CAM therapy in Portugal. Mira (1947), in his book *The History of Portuguese Medicine* gives various examples of Portuguese medical doctors who in the eighteenth century were committed to unorthodox practices, including the manufacture of their own remedies and the incorporation of folk theories about health. Ventura (2007), a popular naturopath within the Portuguese CAM circle, claims that before the revival of CAM in the 1980s, naturopaths such as Indiveri Colucci and medical doctors such as Amílcar de Sousa or Adriano de Oliveira, were among the few supporters of naturopathy, today being considered as the leaders of CAM revival in Portugal. According to Ventura (2007), the efforts of these personalities to institutionalise naturopathy in the country always failed due to the existence of a very conservative society of the time, ruled by a fascist regime.

More recently, however, following the path of many other Western countries, CAM therapies in the country have attempted to acquire legitimacy and occupational closure within

mainstream health-care. The claim for statutory regulation has been paramount. After a long political contest on CAM regulation in the country, on the 22nd August 2003 the Portuguese government approved a new Bill (Bill 45/2003 – *Lei do Enquadramento Base das Terapêuticas Não Convencionais*) which extended regulation to six CAM therapies: acupuncture, homeopathy, osteopathy, chiropractic, naturopathy and phytotherapy (Assembleia da República Portuguesa, 2003). Nevertheless, despite this regulation, the CAM Bill has not yet been implemented. Although CAM remains marginalised by the State, the latter has tolerated the existence of lay CAM practitioners in the country.

Amongst those six CAM therapies, acupuncture and homeopathy are two very interesting case-studies. Although the medical practice of acupuncture in Portugal can be seen to have been in use at least since the 1980s, it was only in 2001 that these professionals acquired the legal right to practise this therapy as a 'medical competency'³. Interestingly, in parallel with the political contest over CAM regulation in the country, which lasted from 1999 to 2003, on the 19th August 2001 the *Portuguese Medical Society of Acupuncture* (*Sociedade Portuguesa Médica de Acupuntura* – SPMA) was set up and tasked with establishing criteria to determine competency in 'medical acupuncture'. Nine months later, on the 14th May 2002, the Portuguese Medical Council approved and applied these criteria to medical doctors. In practice, this move towards the institutional medical acceptance of acupuncture led to the creation of a postgraduate course in 'medical acupuncture' in order to:

... adequately train a higher number of medical doctors to use this therapeutic technique, thus integrating acupuncture in their clinical practice, and basing this practice on clinical and scientific evidence (Faculdade de Ciências Médicas da Universidade de Lisboa [FCMUL], 2009).

³ Although acupuncture was included in an earlier coding of medical acts, as published by the Portuguese Medical Council. Available at: <http://www.nortemedico.pt/textos/?imr=3&imc=6n423n>.

The first institution to welcome the postgraduate course in 'medical acupuncture' was the *Abel Salazar's Biomedical Science Institute* (ICBAS) in Porto. This postgraduate course has since spread around the country and is now being taught in places such as Lisbon and Coimbra. In 2009, according to the Portuguese press, at least 63 medical doctors had acquired the SPMA's accreditation in medical acupuncture in the country (Gomes, 2009). Some aspects of this course are worth mentioning in more detail. In the first place, the course aims specifically to promote the use of 'contemporary medical acupuncture', defined as '... a neuromodulation technique, through the insertion of metallic needles through nerve paths' (FCMUL, 2009), and based on scientific research. Secondly, the entire course is delivered only to medical doctors, even excluding other health-care professionals.

It can thus be illustrated that significant changes have been made concerning the status of acupuncture within the Portuguese medical establishment over the last decade. For, from a therapy practised in the shadows of the legal medical practice, and from a technique based on an ancient Chinese theory, acupuncture has turned into a recognised biomedical technique with increasing scientific evidence and has been incorporated into clinical medical practice. Furthermore, 'medical acupuncture', as integrated into the national health-care system, can only be practised by medical doctors in health-care centres and in hospital settings, even if essentially limited to the area of pain. There is also anecdotal evidence of medical collaboration with CAM in the private sector in 'integrated' clinics.

Homeopathy has not shared this enhanced status with acupuncture in Portugal. Although homeopathy has traditionally been incorporated by a number of medical doctors in the country, and although medical enthusiasm for this therapy can be traced further back in time than for acupuncture, homeopathy essentially remains a rejected and attacked therapy by the Medical Council, which continues to regard it as 'quackery'. Authors like Mira (1947) and Araújo (2005), for instance, have documented

that medical interest in homeopathy in Portugal goes back to the nineteenth century. Araújo (2005) has shown that medical attempts to legalise and accredit homeopathy go back to the second half of the nineteenth century, with the support of sympathetic personalities from the Portuguese aristocracy and from the political, artistic and medical spheres of the time. Many stories abound about these personalities' successful personal use of homeopathy. Moreover, a small fraction of medical doctors have actively worked for the professionalisation of homeopathy in Portugal by setting up homeopathic clinics, professional associations and journals, although these appear to have been extinguished over time. Interestingly, homeopathy was even taught informally in some medical courses by academics who were supporters of this therapy (Araújo, 2005). In turn, Mira (1947) has showed how some nineteenth century Portuguese medical doctors 'seduced' by homeopathy attempted to set up homeopathic *boticas* (an earlier form of pharmacies) and to incorporate homeopathic treatments in public hospitals. The failure of homeopathy's attempts to gain legitimacy in the country can be attributed to the medical resistance of homeopathic ideology, which was seen as 'fallacious' and 'sinister', according to a report by the medical school of surgery of Lisbon of the time (Mira, 1947). This institutional medical position towards homeopathy from two centuries ago does not seem to have changed over time, as homeopathy continues to be seen as an alien and 'Palaeolithic' therapy, as described in the Medical Council's Report on the two CAM Bill projects presented to the Portuguese parliament in 1999 (Secção Regional do Norte da Ordem dos Médicos, 1999).

The tradition of homeopathic associations in Portugal is another significant phenomenon. Araújo (2005) shows, for instance, how the turn of the twentieth century was marked by the setting up of many homeopathic associations by medical doctors and pharmacists, which gradually disappeared over time. At present, there are at least two dominant medical associations of homeopathy in the country: the *Homeopathic Society of Portugal* (*Sociedade Homeopática de*

Portugal – SHP), which was founded in 2003 by a small group of medical doctors and pharmacists, who defined homeopathy as a 'medical approach',⁴ and the *Portuguese Society of Homeopathy* (*Sociedade Portuguesa de Homeopatia* – SPH), about which very little information has been disclosed or provided. These two associations have also set up courses in homeopathy. The extent to which these courses are designed either for medical doctors and other health-care professionals or for people without previous formal health-care training remains ambiguous.

In the past, there was also a strong relationship between medical doctors and pharmacists in Portugal who were both committed to homeopathy, with the setting up of many homeopathic/allopathic pharmacies over time, some of which still remain open today (Araújo, 2005). The medical doctors used to manufacture their own remedies and later requested their remedies be prepared from a *boticário*, a dispensing chemist or an earlier version of the modern pharmacist in the country (Mendes & Braga, 2001). In the same way as medical doctors sought to legitimate homeopathy in relation to their institutional body, pharmacists who were interested in homeopathy in the past used to fight against the Pharmaceutical Council, which was against this therapy as it did not 'dignify' the status of pharmacological science (Araújo, 2005). Ironically, the manufacture, commercialisation and utilisation of homeopathic remedies for human use have been legislated for by the Portuguese government through the Decree-Bill n° 94/95 from 9th May 1995 (and later replaced by the Decree-Bill n.° 176/2006 from 30th August 2006; Ministério da Saúde, 1995, 2006). This decree addressed the increasing use of homeopathic remedies in the country with advisory input from the Medical and Pharmaceutical Councils with regards to the new national directives on the manufacture, commercialisation, labelling and distribution of homeopathic remedies, a

⁴ Sociedade Homeopática de Portugal (SHP; *Homeopathic Society of Portugal*) website. Available at: <http://www.homeopatiaportugal.org/paginas/faqs.php> [Date of access: 5.12.2009].

responsibility which was subsequently placed under the jurisdiction of the *National Authority on Pharmacy and Medicinal Products* (Infarmed – *Autoridade Nacional do Medicamento e dos Produtos de Saúde I.P.*).

The power given to the Medical and the Pharmaceutical Councils by the State to intervene in the decision of the manufacture, commercialisation, labelling and distribution of homeopathic remedies is thus important. The former Decree-Bill n.º 94/95 distinguishes between two sorts of homeopathic remedies: the 'homeopathic drugs' (*medicamentos homeopáticos*), which are defined as having a curative and preventive status and to which directives applicable to conventional drugs are applied; and the 'homeopathic pharmaceutical products' (*produtos farmacêuticos homeopáticos*), relabelled later as 'homeopathic drugs within a simplified regimen' (*medicamentos homeopáticos sujeitos a registo simplificado*) by the Decree-Bill n.º 176/2006. Interestingly, in order to acquire this latter status, homeopathic drugs must meet specific criteria such as being clearly labelled as 'homeopathic drugs without approved therapeutic indications'.

The existence of a strong medical power in Portugal is also an issue worthy of note. Diogo (2004), for instance, pointed to the fact that the creation of the National Health System in 1979 after the political reform of 1974 created a high demand for medical doctors in the country who were seen as a valuable and scarce resource. As a result, incentives were created to increase the number of these professionals through the delegation of power and flexibility given to medical doctors to manage their professional careers. State control over medicine's licensure has traditionally been of significance in the country (Carapinheiro & Rodrigues, 1998) as well. As Carapinheiro and Rodrigues (1998) state, the Portuguese Medical Council was founded in 1938 under a corporatist and authoritarian State that aimed to have total control over medical credentialism in the country. The Medical (as well as the Pharmaceutical) Council is a corporate association for which membership is compulsory (Oliveira, Magone, & Pereira, 2005) which has ethical and disciplinary power

to censure and punish medical doctors (Barros & Simões, 2007). Medical doctors are not permitted to call themselves homeopaths, as according to the Portuguese Medical Council's (2008) *Code of Ethics*, titles other than doctor are prohibited for membership and the Council can exercise disciplinary actions such as banning an individual from practising medicine.

Therefore, at present acupuncture and homeopathy in Portuguese society appear to occupy contrasting statuses within the medical establishment. The former has clearly been co-opted or absorbed by biomedicine, while the latter is still banned by the medical establishment, despite its incorporation at the level of the clinical practice. This dialectic leads us to an exploration of the possible reasons for this differential status of acupuncture and homeopathy within mainstream health-care in Portugal.

METHODOLOGY

The main sources of this study come from medical doctors committed to acupuncture and homeopathy in Portugal who will be respectively referred to as 'medical acupuncturists' and 'medical homeopaths' from hereon in. Medical acupuncturists, on the one hand, are traditionally qualified medical doctors who have acquired accreditation in medical acupuncture by the Portuguese Medical Council or, having not acquired this accreditation, still use this therapy in their medical practice. Medical homeopaths, on the other hand, are traditionally qualified medical doctors who have acquired training in homeopathy inside or outside the country and who have incorporated it into their medical practice. They are not accredited medical homeopaths, as there is no accreditation in medical homeopathy.

The researcher conducted 11 in-depth interviews with medical acupuncturists and medical homeopaths. As Table 1 shows, most of these professionals (six) were committed to both acupuncture and homeopathy. Among the remaining five, two were committed only to homeopathy while the other three were committed solely to acupuncture. Amongst the medical doctors committed to acupuncture (nine),

TABLE 1: PARTICIPANTS ACCORDING TO THEIR COMMITMENT TO ACUPUNCTURE/HOMEOPATHY

Accredited acupuncturist	Non- accredited acupuncturist	Practising homeopathy	Grassroots	Leader/ representative
X				X
X		X		X
X		X		X
X		X		X
X			X	
	X	X	X	
	X	X	X	
	X	X		X
	X		X	
		X	X	
		X	X	

five were accredited medical acupuncturists and four were non-accredited medical acupuncturists. Finally, from these 11 participants, five were representatives from medical institutions involving acupuncture and homeopathy in the country.

Some participants were selected using a snow-ball approach (six), while others were intentionally contacted due to their key position as representatives from medical institutions of acupuncture and homeopathy (five). The interviews were conducted between June 2008 and April 2009. The length of the interviews ranged from 50 minutes to 2 hours. All the interviews were taped and fully transcribed using the computer program Transana 2.12. The interviews were later transferred to an Atlas.ti program through which a preliminary list of thematic categories was elicited. The researcher undertook further sociological analysis of the data by hand, systematically comparing the data from the various respondents.

The researcher has given serious consideration to ethical issues involving her research. Permission for the research was approved through the Departmental Ethics Committee from the researcher's academic institution. The researcher safeguarded the anonymity of the participants by preserving the privacy of their names. All of the interviews were based on the

fully informed consent of participants. Finally, the researcher has sought to attain a degree of impartiality in the analysis and discussion of the data through commitment to accurately reflect the views portrayed in participants' accounts.

RESULTS

This section examines the reasons for the differential incorporation of acupuncture and homeopathy into the medical establishment in Portugal based on the views of medical doctors who have embraced acupuncture and homeopathy and incorporated them into their daily medical practice.

Factors influencing the differential status of acupuncture and homeopathy within the medical establishment in Portugal – Medical insiders' views

Lack of scientific evidence or medical prejudice?

The rhetoric of the lack of scientific evidence of CAM pervaded all the participants' accounts. Interestingly, mainly amongst medical acupuncturists, the idea that homeopathy lacks scientific evidence was seen as its main legitimacy problem. For instance, one accredited medical acupuncturist who represented the SPMA, compared acupuncture and homeopathy in the following way:

As far as I know the weak thing about homeopathy is the lack of scientific evidence. So, in acupuncture we can scientifically show that there are situations where it [acupuncture] works or doesn't work ... in randomised trials, by comparing groups [...] But in homeopathy as far as I know we cannot reach an explanation for the way it works and why it works. They [researchers] give a placebo remedy and then a homeopathic remedy and they get most of the time positive results I think. Or they get positive results in many cases let's say. But how does it work then?

As far as I know, and you can ask [medical homeopaths] this, it's not that easy to explain [how homeopathy works]. And nowadays with acupuncture we already know how it works and we can validate its results.

This statement illustrates a very institutional viewpoint coming from a participant with a key role in the accreditation of 'medical acupuncture' in the country. It is of interest to note that this interviewee demarcated acupuncture from homeopathy by using the scientific validation argument. Such demarcation indicates the existence of a biomedical stratification within CAM based on scientific evidence criteria. Although this medical acupuncturist supported homeopathy by saying that it often works, he also claimed that it can not be scientifically validated in the same way that acupuncture has been. In other words, what is claimed here is that homeopathy has not yet acquired biomedical interpretation and legitimacy.

Conversely, among medical homeopaths, the argument of homeopathy's lack of scientific evidence base was seen as absurd and not without criticism. The following non-accredited medical acupuncturist who was committed to homeopathy and who was a representative from the SPH, when asked why the Medical Council still rejects homeopathy, sarcastically pointed out:

Well, why doesn't the Medical Council accept it [homeopathy]? It would be better to ask the Council. But what they [the Council] have publicly said is that it [homeopathy] doesn't have a scientific basis. And according to them [the Council] [homeopathy] doesn't have a scientific basis because there aren't enough clinical studies and research to give credibility or an explanation to the way homeopathic remedies work. I think this is not the fact, as there is already huge scientific research published in renowned international journals by researchers ... either medical doctors or scientists from different fields who in fact document the use of homeopathic remedies with specific clinical results.

In the same way as this medical doctor, several others have claimed that the Council's argument

of homeopathy's lack of scientific evidence base is a disingenuous argument and is used as a convenient explanation for rejecting this therapy, as there has been considerable research done on homeopathy with clear results of its success. One of the medical doctors, an accredited medical acupuncturist who was also committed to homeopathy and who was a representative from the SHP, declared that homeopathy and not acupuncture should have been the first one to be recognised by the Council, based on the broader research on the former compared with the latter:

It should have been the other way round. Because we have research on homeopathy and much less research on acupuncture.

The idea encapsulated in the long statement below of an accredited medical acupuncturist, a representative from the SPMA and from the Infarmed (*National Authority on Pharmacy and Medicinal Products*) who was committed to homeopathy, is representative of most of the respondents' perspectives on the current status of homeopathy within the Portuguese medical establishment:

JA: What do you think about the future of homeopathy within medicine?

I: It's difficult. It's very difficult. It's difficult because there are big pressures, much prejudice in relation to homeopathy.

JA: By the medical doctors?

I: Yeah, from a certain sector of conventional medicine.

JA: Do you think it's just prejudice?

I: Yes, there is much prejudice, for sure. Much, much prejudice. And the rejection of certain evidence.

JA: You mean scientific evidence? Does homeopathy have scientific evidence?

I: Yes, it has. It has scientific evidence, not so much as acupuncture, for instance, but it has enough scientific evidence to be considered as a valid therapy for many conditions.

JA: The question about the dilution under the Avogadro's number ...

I: Yeah, it's a complicated question because if they [the Medical Council] don't accept that there is in fact something there, it will be difficult to move forward.

JA: And is it really proven that the information remains there [in the water] in fact?

I: From the point of view of the Physics, yes, it's already proven. But just from a Physics' stance, at the moment ...

JA: And do you think that sooner or later it will be ...

I: I don't know, really. Sometimes ... well ... sometimes the world is so cruel, right, the evolution of things is a bit cruel and sometimes what benefits it's not always the best thing, right? We've seen that in human history, right? Sometimes only in the future, right? Copernicus also had troubles ... Galileo, etc.

JA: Do you think that the Medical Council ...

I: That's a group. A group. It's not only a person. It's an influential group. Because then ... look ... there are many people who could risk their position if they showed interest in something like this [homeopathy]. They would risk their position a lot. If they happen to have an important position. So, it's better to be careful. And I can understand that.

What is being claimed by this interviewee is that while homeopathy has been increasingly proven by scientific research, often with clearly good results for certain health-care conditions, orthodox medicine, motivated by prejudice, is still resistant to it. This participant referred to 'resistance to innovation' (Jones, 2004) and compared homeopathy to some other 'heresies' which were later incorporated into mainstream science. Furthermore, the interviewee emphasised that whilst the 'medical heretics' (Dew, 2000) within the Council could embrace homeopathy, this

would come at great risk. The underlying premise of this quote seems to underestimate the medical argument of the scientific implausibility of homeopathy by instead highlighting the role of power, status and lobbying relationships within the Medical Council which have served to undermine the legitimacy of this therapy. This respondent made it very clear that in their view, without the influential Medical Council's acceptance of homeopathy's rationale, it would be impossible for this therapy to move away from the margins.

The prejudice and 'resistance to innovation' attributed to the Portuguese medical elite could be regarded as a manifestation of the traditional power of the Medical Council in Portugal, in particular the ethical and disciplinary power this institution has over its members. Although banned by the Medical Council, homeopathy continues to be practised by a few medical doctors in the country. The concern about disclosing their commitment to a 'forbidden therapy' was a concern that many of the medical homeopaths raised to some degree. For example, one grassroots medical homeopath clearly showed discomfort in disclosing having homeopathic training as it could give rise to potential conflicts with the Council and the subsequent banishment from practising medicine:

I've got training in homeopathy. I never put it in my CV as I would be banned from the Medical Council, yet I've got training in homeopathy for a long time. So, I'm a fellow member of the Royal London Homeopathic Hospital,⁵ but in fact I've never written down this [in my CV] as I would be, as I said, expelled from the Medical Council. Presently homeopathy has changed, it can be found in every pharmacy, even if the Medical Council doesn't accept it but that's obvious that someone needs to practise it.

Those medical doctors practising homeopathy in this study often seemed to use strategies to protect themselves from the Council, as the following example from a medical homeopath

⁵ Now known as the *Royal London Hospital for Integrated Medicine*.

who was a representative from one of the medical associations of homeopathy in the country disclosed:

I usually say I'm the chair of the [name of the institution]. I cannot say I'm a homeopath because a friend of mine was penalised as it [homeopathy] doesn't exist neither as a speciality nor as a competency in our country and so medical doctors cannot claim a title that doesn't exist. ... So, I usually say I'm the chairman [of the medical homeopathic association]. 'Am I a homeopath'? 'No'.

Despite the institutional barriers to developing and delivering formal training in medical homeopathy, the medical doctors from this study acquired homeopathic training either inside or outside the country. Although the nature of some training courses remained ambiguous, some participants disclosed the involvement of the pharmaceutical laboratories in their organisation:

JA: Was it in Portugal, the course you attended?

I: Yes. It was in Portugal but it was a French laboratory, Boiron, which gave training here in the country to the ones interested [in homeopathy]. Actually there were very few people interested [in homeopathy]. We were in total around 20 medical doctors. This was about 20 years ago. Less than 20 years.

JA: Was it only for medical doctors?

I: ... Only medical doctors and pharmacists. And was delivered by medical doctors.

Although the above quotation is illustrative of the way in which medical doctors used to acquire credentialism in homeopathy during the 1990s, this situation does not appear to have changed. The most common ways to acquire credentialism in homeopathy have been to seek training abroad and to attend informal and private courses organised by pharmaceutical laboratories and medical homeopathic associations in the country. There was also anecdotal evidence of medical doctors drawing on the expertise

of lay homeopaths without actually associating themselves with lay homeopathic groups.

The marginal place that homeopathy currently occupies in the medical establishment at a macro-level is reminiscent of the place occupied by acupuncture during the 1980s, before its incorporation into the medical establishment. One accredited medical acupuncturist who was committed to homeopathy and who was a representative from the SPMA put it very clearly when talking about the early medical promotion of acupuncture in the country:

By that time, let's say ... in the 80's, there were courses for medical doctors ... in Portugal ... but they were private courses, you see? ... The courses were run by those who had already started learning acupuncture and thought it would be interesting to share [that learning] with other colleagues who couldn't leave the country ... there were [courses] in Porto even in the ICBAS [Abel Salazar's Biomedical Science Institute] premises ... you see, it wasn't a course from the university but they, let's say, lent the premises and that's how the medical promotion [in acupuncture] started.

Further factors perceived as having influenced the differential status of acupuncture and homeopathy within the medical establishment were related to the idiosyncrasies of these two therapies and to power and economic interests between them, the medical orthodoxy and the pharmaceutical industry. This paper will now turn to the analysis of these aspects.

Idiosyncrasies of acupuncture and homeopathy

The medical prejudice and 'resistance to innovation' in the case of homeopathy was often associated with this therapy's idiosyncrasies. The differential incorporation of acupuncture and homeopathy were rendered particularly distinctive when definitions of these two therapies and their comparisons with the biomedical ideology were disclosed among the participants. It is therefore pertinent to define briefly the underlying purposes for acupuncture and homeopathy's rationale.

Acupuncture is an ancient therapeutic technique of Chinese medicine which consists of the insertion of fine needles in specific acupoints in the body (Gwei-Djen & Needham, 1980). In its classical mould, it is a main component of Traditional Chinese Medicine and is informed by a Chinese theory of treating *qi* (energy) flow imbalances and therefore restoring health. Acupuncture is thus an ancient needle therapy and is therefore a drugless technique imported from the East. Homeopathy, in turn, presents as a nineteenth-century non-allopathic medicinal system (Fulder, 1996) based on three main principles: 'the simile', or the idea that treatment should be based on a drug-symptom similarity (Nicholls, 1988); the principle of the minimum dose, in contrast with the biomedical perspective that accepts doses that can be increased by combining different drugs (Nicholls, 1988); and the principle of high dilutions or potencies i.e. the idea that remedies can retain their power after being diluted and agitated beyond the Avogadro's number, from which it is scientifically believed that no more molecules of the original substance remain (Degele, 2005). In short, homeopathy presents itself as a Western medicinal system with an ideology of healing which is predominantly contradictory to the biomedical one,⁶ yet which also lays claim to the use of medicinal substances with a pharmacological or chemical influence (Nicholls, 1988). Nevertheless, the homeopathic pharmacopeia is considered very distinctive and antagonistic to the biomedical one, due to the principles outlined above.

From the perspective of some interviewees, one of the main focuses of conflict between homeopathy and the medical establishment was the presence of an esoteric homeopathic theory underlying healing practices. Homeopathy has not yet acquired a biomedical interpretation and is therefore still seen as quackery and rejected by the Medical Council. For instance, homeopathy's use of substances without proven efficacy

was often emphasised. As a grassroots accredited medical acupuncturist put it:

Look, acupuncture is only a technique that uses needles without chemicals, without remedies, by neural stimulation, while homeopathy uses remedies which perhaps we still need to know where the benefit starts and where the non benefit ends. That's the difference [between acupuncture and homeopathy], I believe.

This last statement clearly opposes acupuncture to homeopathy in relation to their idiosyncrasies. Acupuncture is seen as a technique where the key instrument of healing is a needle and not drugs or some other internal remedy. Although this quotation emphasises the biomedical co-optation of acupuncture by reducing it to a biomedical technique through defining it as a neural stimulation, it still points to its ancient roots as a drugless and extraneous technique. Indeed, adopting a social closure theory of this view, it could be argued that the drugless nature of acupuncture has not represented a threat to the hegemony of the biomedical ideology in fields such as pharmacology or pharmaceuticals, thus making it amendable to biomedicine. Homeopathy, on the other hand, is related to the use of remedies which have unpredictable results. Such a view is reflective of the esoteric homeopathic theory that has traditionally been attributed to these remedies by the medical establishment. Furthermore, by stating what acupuncture is not, the interviewee attempted to address a pharmacological influence on homeopathy, which within a framework of countervailing powers, is indicative of the potential power imbalance that this therapy might cause in biomedicine's relationship with the pharmaceutical industry.

Indeed, some other participants showed concern about the ongoing dynamics between homeopathy, medical orthodoxy and the pharmaceutical industry worldwide. In this respect, an accredited medical acupuncturist who was a representative from the SPMA disclosed that the pharmaceutical influence of this therapy may challenge the relationship between medical orthodoxy and the pharmaceutical industry and

⁶ Although biomedicine often uses treatments based on the simile principle such as vaccination (Nicholls, 1988).

so may be one of the reasons why it has not been accepted by the Council:

Homeopathy gets into another area which is the pharmaceutical one, the pharmaceutical industry. And there will be big economic interests too ... but I'm not sure if it's only that. Because in France, for instance, homeopathy is widely promoted and there are [specialist homeopathic] pharmacies and so on ... I think that has to do a bit with both the issues. With commercial aspects ... but within the Medical Council ... I think it's more the lack of scientific evidence. Try and ask my colleagues 'so, how does homeopathy work'? Do they really know? I think they don't understand it very well.

It is interesting to note that the comments pertaining to the medical profession's interests and to its relationship with the pharmaceutical industry arose from medical insiders, i.e., orthodox medical doctors. This participant claimed that the economic and commercial interests of the pharmaceutical industry in relation to homeopathy, which evoke the potential marketing of homeopathic remedies and research funding in homeopathy, may capitalise on homeopathy and may therefore contribute to the institutional medical rejection of this therapy. The participant referred to the example of France, a major producer and consumer of CAM remedies (Ramsey, 1999) which are dispensed in almost all pharmacies (House of Commons, 2010). Nevertheless, CAM practice in France is monopolised by medical insiders such as medical doctors and forbidden to medical outsiders (Ramsey, 1999) such as lay acupuncturists or lay homeopaths.

In Portugal, the current consumerism and supply of CAM remedies are far from being as significant as they have been in France. Lay confidence and trust in medical doctors and in orthodox health-care in Portugal remains at a high level (Cabral, Silva, & Mendes, 2002). Furthermore, lay autonomy towards 'medical power' in Portugal is one of the lowest in Europe (Alcântara & Cabral, 2007). Therefore, lay perceptions of homeopathy are still highly

influenced by the institutional medical rhetoric around this therapy. In addition to this, homeopathy has neither achieved statutory regulation nor acquired institutional medical recognition. Consequently, homeopathic remedies have not merited significant lay interest and have therefore not been profitable. However, the CAM Bill 45/2003, if implemented, depicts an attractive scenario for both lay homeopaths and the pharmaceutical industry in the country. While lay homeopaths may be regulated and consequently provide homeopathic treatments and prescribe homeopathic remedies,⁷ the pharmaceutical industry may capitalise on such remedies and have a stake in the potential trend of emerging lay interest in homeopathy. However, claims about the strong link between the pharmaceutical industry and the medical establishment in the country through the pharma's commissioning of or funding for biomedical research and education were also highlighted by a few respondents in this study. As the following accredited medical acupuncturist, a representative from the SHP and also a medical homeopath disclosed:

Because there are lobbying groups within the Medical Council. As I said, the laboratories are the ones who control the high education's training. They financially support everything. The research carried out in the hospitals. The laboratories, the multinationals ... after the army industry is the pharmaceutical industry [the most powerful one].

DISCUSSION

This paper has examined the extent to which acupuncture and homeopathy have enhanced their status within the medical establishment in Portugal and the reasons for their differential incorporation into the Portuguese medical establishment.

It has been shown that in Portugal the interest of individual medical doctors in acupuncture

⁷ In 'Homeopatia: Proposta Completa', the proposal submitted to the Ministry of Health by representatives of homeopathy from the consultative Commission tasked with the establishment of the criteria for CAM statutory regulation in the country.

and homeopathy has proceeded institutional medical interest in these therapies. With regards to acupuncture, the medical interest in this therapy appears to have begun to increase since the 1980s. However, it was only in the following two decades, at the turn of the twenty-first century, that the Portuguese Medical Council shifted its perspective from a position of rejection to one of tacit incorporation of this therapy. This medical institutionalisation of acupuncture in Portugal involved the creation of the SPMA and the notion of medical competency in this therapy. It seems therefore, that in relation to acupuncture, Portugal has followed a similar path to other Western Countries. This therapy has been co-opted by biomedicine and absorbed by biomedical theory. Furthermore, it has been incorporated into the national health-care system, being practised by medical doctors with competency in 'medical acupuncture' and limited to specific medical conditions, such as those involving pain.⁸ For all these changes, acupuncture has acquired a privileged status within Portuguese health-care, being the only CAM therapy to date to have gained medical recognition.

Despite these recent moves, the delay of the country in providing institutional medical recognition of acupuncture compared with other Western countries should not be underestimated. Nor should the extensive time period that elapsed while acupuncture went from being a grassroots medical concern to acquiring institutional medical interest. Such delays may be both attributable to, and illustrative of the role of the Portuguese Medical Council as a powerful and influential actor in Portuguese health-care (Carapinheiro, 2005; Carapinheiro & Rodrigues, 1998), with vested interests in medical corporatism, occupational closure and demarcation (Carapinheiro & Rodrigues, 1998).

⁸ Despite the recent claims of the S.P.M.A. to extend the use of medical acupuncture within the health-care system to branches of medicine such as general practice, obstetrics and gynaecology. See the SPMA website <http://www.spma.pt> [Date of access: 30.11.2010].

The findings from this research also suggest that the Portuguese incorporationist scenario pertaining to acupuncture seems not to have been observed in the biomedical reaction to homeopathy. Although there has been a small fraction of medical doctors in the country who have been committed to this therapy for a long time and who have fought for its medical recognition, the Council still prohibits and attacks its practice. Among the respondents from this study, there was a common concern about disclosing their commitment to this therapy, which may reflect the disciplinary power of the Council in the country and the impact of this on medical rhetoric. So, in contrast to acupuncture, homeopathy has neither been incorporated into, nor enhanced its legitimacy within the medical establishment. Recalling Van Haselen (2005), the debate surrounding homeopathy within the Portuguese medical establishment is still more about 'should homeopathy be present at all' than about its possible routes of incorporation into the formal health-care system, as has happened in some Western countries.

The biomedical rhetoric about homeopathy's lack of scientific evidence, for instance, was interpreted as disingenuous as well as a merely convenient explanation for rejecting homeopathy. Prejudice and 'resistance to innovation' (Jones, 2004) such as resistance to the homeopathic ideology were essentially seen as the Council's responses to homeopathy. Interestingly, the medical interest in homeopathy in the country goes further back than that in acupuncture. Homeopathy in the country goes back to the nineteenth century, to a time when medicine itself began to undergo a process of professionalisation, and was still negotiating the balance between science and mysticism (Araújo, 2005). At that time, a small fraction of the medical doctors actively advocated the professionalisation of homeopathy in Portugal, in addition to which there were a few attempts to legalise and accredit homeopathy in the country. So, it seems that the significant tradition of homeopathy within the medical circle in Portugal has been ignored over time, as it never gained the support of the conservative medical establishment and was not

able to fight against the biomedical ideology of health-care that also penetrated in Portugal.

Ironically, the manufacture and commercialisation of a number of homeopathic remedies for human use have been allowed in the country since 1995, although some remedies require a disclosure that they are without proven therapeutic outcomes. This last aspect raises a very interesting question: if it is biomedically perceived that some homeopathic remedies do not have therapeutic indications, and if homeopathy's lack of scientific evidence seems to concern the medical orthodoxy the most, on what basis are they being sold in the health-care market? In this respect, Law (2006) for instance, suggests that medical doctors are hopeless brakes in the pharmaceutical industry's need to prosper and to expand its market. This means that focusing solely on the rhetoric of the lack of scientific evidence of CAM or on medical prejudice and 'resistance to innovation' can obscure commercial and economic factors that may also be responsible for or contribute to the ban on homeopathy by the Portuguese Medical Council.

Acupuncture, it has been argued here, has acquired higher status within the Portuguese medical orthodoxy in part because of its drugless use, which does not overtly threaten either the pharmaceutical nature of biomedicine or its alliance with such actors as the pharmaceutical industry.⁹ However, it may threaten the pharma industry itself, as it may provide a 'more socially acceptable, tolerable and inexpensive (treatment) than the more conventional drugs manufactured by the pharmaceutical industry' (Rathbone & Xia, 2009). It was disclosed by the respondents in this study that homeopathy has a pharmaceutical influence, in the sense that some of the homeopathic remedies can have biochemical origins. As was alluded to earlier, until very recently the pharmaceutical industry had underestimated the homeopathic market. Now, in line with its profit and patient oriented

ideology (Law, 2006), this actor has acquired increasing interest in homeopathy, as the latter has attained greater social recognition and subsequently stimulated drugs sales. This could lead to an imbalanced state of power between the pharma industry and the medical profession and could also represent a threat to the hegemony of the biomedical ideology within the pharmaceutical industry.

This recent incursion of the pharma industry into the homeopathic market leads to further speculation about the future scenario of homeopathy within the Portuguese health-care system. First, how far can the pharmaceutical interest in homeopathy go in the Portuguese context? Consequently, to what extent can the pharma's emerging interest in homeopathy change its balance of power with the medical profession? Finally, to what extent can the pharma industry pressurise the latter to change its position towards homeopathy? As Light (1995, p. 33) has emphasised, the implication of countervailing games 'is that each party has legitimate goals and values which are not easy to fit with the others and which can lead to serious imbalances in their own right'. As a profit-oriented institution, the pharma industry has been exploring and promoting homeopathy in the health-care market. And as a very powerful and influential institution which has a strong relationship with the public, it may contribute to enhancing homeopathy's legitimacy and scientific credibility.

Furthermore, if the emerging relationship between the pharmaceutical industry and homeopathy was to result in greater scientific evidence being established for the latter, for example through the commissioning or funding of homeopathic research, then the medical orthodoxy would be expected to counteract this move through ensuring that it maintains its dominant status and power within the health-care system. One such strategy might be to open its doors to this therapy. In the case of Portugal, where the rhetoric about the lack of scientific evidence of homeopathy and medical prejudice towards this therapy have sharply characterised the institutional medical position, the emerging

⁹ Although its cousin mesopuncture, which deals with the injection of a product into acupuncture points, may pose a threat to such an alliance.

interest of the pharmaceutical industry in homeopathy and the potential increase in its scientific evidence base could represent a shift towards this therapy's status within the medical establishment. This could mean a change from the long-standing institutional medical position of rejection to one of 'enhanced legitimacy' or even to the incorporation of homeopathy in the country. This would render Portugal closer to countries where homeopathy has been amenable to biomedicine. However, were this scenario to occur and homeopathy acquired greater medical legitimacy, this would not necessarily be a direct consequence of its increasing scientific evidence base (the reason for its current rejection), but rather because of the wider professional and socioeconomic interests that have contributed to shaping health-care more generally.

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